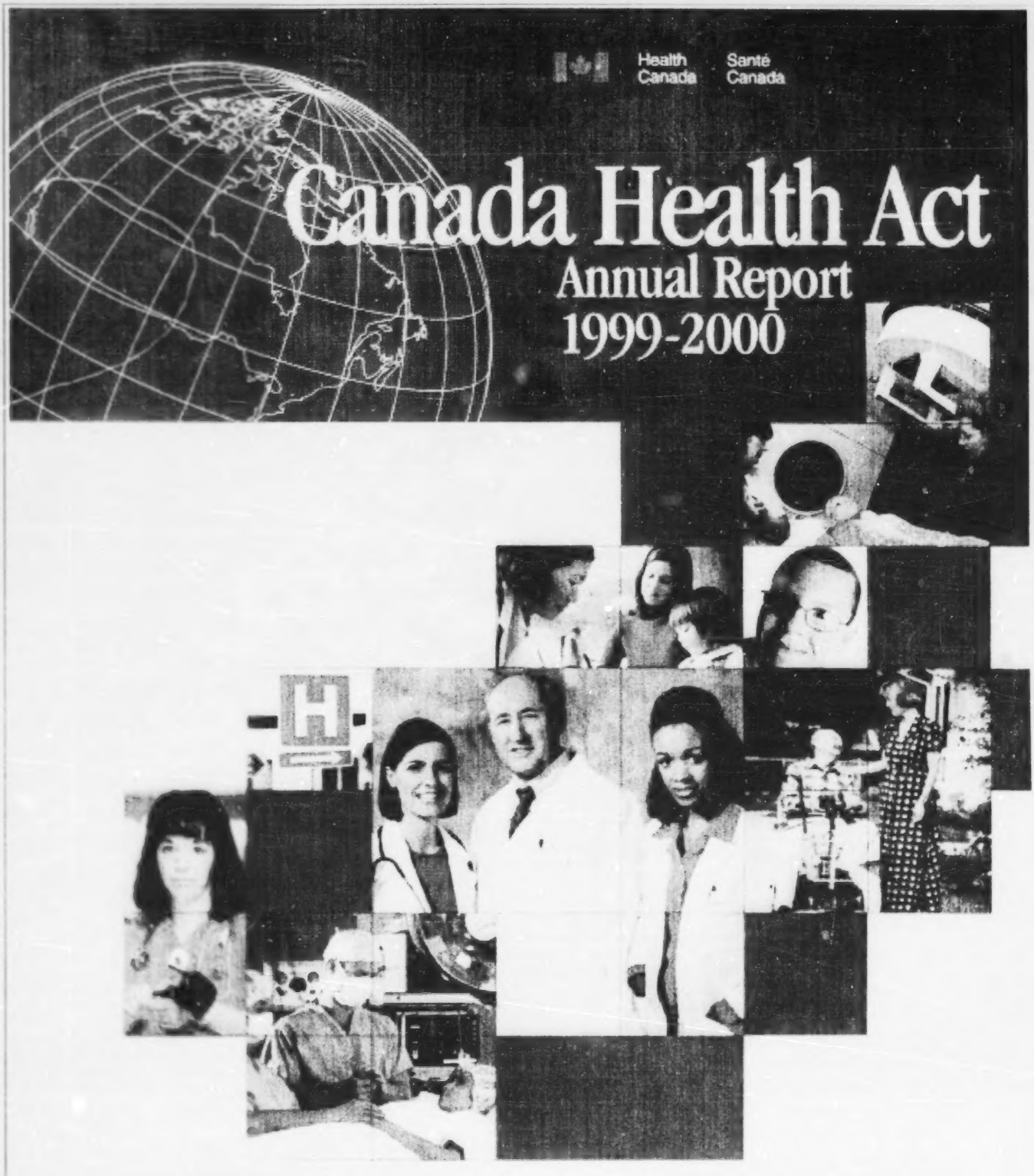
Health Canada
Santé Canada
Canada Health Act
Annual Report
1999-2000
Canada

Our mission is to help the people of Canada maintain and improve their health.

Health Canada

Information on the *Canada Health Act* and related material can be found on the Internet at *http://www.hc-sc.gc.ca/medicare*

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Her Excellency, the Right Honourable Adrienne Clarkson, Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year ended March 31, 2000.

Allan Rock
Minister of Health

Preface

The five principles embodied in the *Canada Health Act* are the cornerstone of the Canadian system of medicare and have iconic status for Canadians. Canadians expect the federal government to live up to its responsibilities under the Act and to take such steps as are necessary to ensure the sustainability of our Canadian universal, portable, accessible, comprehensive and publicly administered health care system.

As our fiscal outlook has continued to improve, the federal government has been able to build on the significant investment for health committed through the February 1999 Budget. Budget 2000 followed with additional investments and, finally, on September 11, 2000, the efforts of all governments to develop a shared plan to improve the quality and responsiveness of our health care system paid off when First Ministers reached an historic agreement. The health accord includes a vision, principles, an action plan, a commitment to report to Canadians, and substantial new federal funding. By working together to implement this accord, governments will ensure the renewal and strengthening of our health care system for the benefit of all Canadians.

First Ministers enunciated their vision of health as follows:

> *Canadians will have publicly funded health services that provide quality health care and that promote the health and well-being of Canadians in a cost-effective and fair manner.*

First Ministers are committed to strengthening and renewing Canada's publicly funded health care services through partnership and collaboration.

First Ministers outlined their key goals for the health care system: to preserve, protect and improve the health of Canadians; to ensure that Canadians have reasonably timely access to an appropriate, integrated, and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and to ensure its long-term sustainability so that health care services are available when needed by Canadians in future years. Among First Ministers' commitments in achieving these goals was a reaffirmation of their commitment to support the principles of the *Canada Health Act* that underpin our health care system.

As a result of this new agreement, the federal government will be increasing its cash transfer payments in support of health to the provinces and territories under the Canada Health and Social Transfer by an additional $18.9 billion over the next five years. In addition to the increase in the transfer payments, $2.3 billion will be provided to the provinces and territories to support primary health care initiatives, to assist in upgrading necessary diagnostic and treatment equipment, and to expand and better coordinate the application of information and communication technologies to the health system to address patient needs. The new agreement helps us immediately in dealing with current challenges and, over the long term, provides a solid basis for health system renewal.

In 1999, the Auditor General of Canada noted that "Health Canada does not have the information it needs to effectively monitor and report on the extent of compliance with the *Canada Health Act*." Responding to this concern, we have begun a process that will standardize the format of the report to ensure a comprehensive and consistent approach to the administration of the Act. We have expanded the range and depth of information to facilitate a better understanding of whether the *Canada Health Act* is being complied with by the provinces and territories.

Furthermore, in May 2000, I made a commitment to strengthen Health Canada's capacity to monitor *Canada Health Act* compliance. I announced a $4 million increase in annual funding to enhance Health Canada's monitoring and enforcement capacity in regional offices and at headquarters. These new resources will better enable Health Canada to work with the provinces and territories, to report on matters of compliance, and allow for an expansion of our information collection and analysis capacity.

In previous years, the *Canada Health Act Annual Report* has listed provinces with compliance issues and noted whether they have been resolved. Nova Scotia remains in a position of non-compliance with the Act concerning the federal policy on private clinics and, as a result, deductions from the federal transfer payments to the province will continue until the issue can be resolved.

After you have read this year's annual report, I hope you will take the time to complete and return the enclosed Feedback Questionnaire. Your comments and suggestions will be helpful in determining the form and content of future reports.

Allan Rock
Minister of Health

Acknowledgements

Health Canada would like to acknowledge the work and effort that went into producing this annual report. It is through the dedication and timely commitments of the following departments of health and their staff that we bring to you this report on the administration and operation of the *Canada Health Act*:

Newfoundland and Labrador Department of Health and Community Services

Prince Edward Island Health and Social Services

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

Ministère de la Santé et des Services sociaux du Québec

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

British Columbia Ministry of Health and Ministry Responsible for Seniors

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

We also greatly appreciate the extensive work effort that was put into this report by our production team: the dedication and long hours devoted by the desktop publishing unit, the graphics company for our new cover design, and all the federal government translators, editors and concordance experts.

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Introduction

Canada Health Act Annual Report

The five principles of the *Canada Health Act* (CHA) are the cornerstone of the Canadian health system, and have iconic status for Canadians. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* provides the provinces and territories with criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

The purpose of the *Canada Health Act Annual Report* is to meet the requirements stated in section 23 of the Act, namely that:

> "The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed."

Under the *Canada Health Act*, provinces and territories are required to provide information on the operation of their health care plans as they relate to the criteria and conditions of the Act. The approach to this information gathering has been collaborative, where provinces, territories and the federal government have worked together to supply the information needed by the Minister to fulfill his responsibilities in administering the Act.

The Auditor General's Report, 1999

On November 29, 1999, the Auditor General of Canada released his Annual Report with Chapter 29 focusing on Federal Support of Health Care Delivery, including administration of the *Canada Health Act*. The Report acknowledges the significance of the *Canada Health Act* to Canadians and its symbolic representation of the values that Canadians have come to view as part of who we are as a society as well as a basic right. The sustainability of universal publicly-funded health care is a major preoccupation of Canadians and there is an expectation that all levels of government will work in close partnership to protect this most cherished social program. Key to accomplishing this goal is adherence to the principles of the *Canada Health Act*.

In its response to the Auditor General's recommendations, Health Canada agreed to work with provincial and territorial partners to improve reporting to Parliament through the *Canada Health Act Annual Report* on the extent to which provincial and territorial health care insurance plans have satisfied the criteria and conditions of the Act. This new approach includes Health Canada's efforts to strengthen its information sources and reporting practices

on provincial and territorial compliance with the *Canada Health Act*. The resulting enhanced sections of this year's Report improve the detail and consistency in the reporting of information and will facilitate a better understanding of activities in the Canadian health system as they relate to the *Canada Health Act*.

Enhancements to the 1999-2000 Annual Report

As one step in implementing our *Canada Health Act* information strategy, Health Canada has expanded the content and changed the format of the *Canada Health Act Annual Report*. Our goal is to make the Report more useful to parliamentarians and the general public by providing information that is relevant to the administration and operation of the *Canada Health Act*. Readers will be able to more easily understand health insurance programs and services in each province and territory.

- The introduction of the Report has been expanded to include key changes to provincial/territorial health insurance plans for 1999-2000 and to provide an indication of what to expect in subsequent annual reports.
- The *Canada Health Act* Overview has been expanded to provide a basic overview of the Act and importantly, the health care services that are not covered by the Act.
- The *Canada Health Act* Administration section includes a discussion of key initiatives and tasks undertaken by the Department over the past year that relate to the *Canada Health Act*.
- Federal Contributions and Payments describes the evolution of the federal funding agreements in support of provincial/territorial health programs, and also notes any deductions made from the federal cash transfer in 1999-2000.
- The provincial and territorial sections have been enhanced to include more consistent narrative descriptions of the workings of each jurisdiction's health care insurance plan.
- Two annexes have been added to the Report. The first contains statistical data on insured hospital, physician, and surgical dental health services. The second, which incorporates all the amendments to the Act since its proclamation in 1984, is an office consolidation of the *Canada Health Act*.
- A glossary has been included to assist in the explanation of terms used in the Annual Report. Where provincial/ territorial terminology differs from those terms identified, this has been indicated.
- Finally, a feedback questionnaire has been added to obtain opinions from Canadians on the new format of the Annual Report. The responses from this questionnaire will assist in the preparation of future annual reports.

Key Changes to Provincial and Territorial Health Insurance Plans in 1999-2000

During 1999-2000, provincial and territorial health insurance plans continued to provide access to a comprehensive range of hospital, physician and extended health care services.

In most provinces and territories, new measures related to the supply of health human resources, particularly physicians and nurses, were announced or implemented.

These measures include recruitment and retention strategies for physicians; an increased number of training positions for medical students; enrichment of bursary programs for undergraduate medical students and medical residents; improvements to rural practice enhancement training programs, and new funding for additional nursing positions.

Provincial and territorial authorities also took steps in 1999-2000 to improve access to insured hospital services. These measures include the opening of new acute and chronic care beds; resources to address waiting lists for medical treatments, surgeries and cancer treatments; the purchase and installation of new high-tech diagnostic equipment, such as magnetic resonance imaging (MRI) and computed tomography (CT); and expansion of telehealth services.

All provinces and territories provide a range of health care services that go beyond the requirements (criteria) of the *Canada Heath Act*. These additional benefits include programs such as pharmacare, home care, ambulance services, and aids to independent living. Such services and benefits are provided at provincial and territorial discretion, and on their own terms and conditions.

What's Coming for 2000-2001?

Health Canada is strengthening its policy analysis and reporting capacity on the *Canada Health Act*. In May 2000, the federal Minister of Health committed to strengthening Health Canada's capacity to monitor *Canada Health Act* compliance. He announced a $4 million increase, for a total of $5.5 million annually, to enhance Health Canada's monitoring and enforcement capacity, in regional offices and at headquarters. These new resources will better enable Health Canada to work with the provinces and territories, to report on matters of compliance, and allow for an expansion of our information collection and analysis capacity.

As part of our efforts to improve our information holdings, Health Canada has undertaken some new initiatives that will be described in the 2000-2001 Annual Report. For example, the Department, in cooperation with the provinces and territories, is studying the supply, demand, and delivery trends of selected high-technology diagnostic services across the country. In addition, an information system and database on publicly insured health programs and services relevant to the *Canada Health Act* is being developed. It is expected that the format and content of the *Canada Health Act Annual Report* will continue to evolve over the coming years to reflect these and other initiatives.

Canada Health Act Overview

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

(Justice Emmett M. Hall)

What is the Canada Health Act?

The *Canada Health Act* is Canada's federal health insurance legislation.

The provinces and territories of Canada are constitutionally responsible for the administration and delivery of health care services. They decide where their hospitals will be located, how many physicians they will need, and how much money they will spend on their health care systems. The *Canada Health Act* establishes the criteria and conditions related to insured health care services—the national standards—that the provinces and territories must meet in order to receive the full federal cash transfer contribution under the transfer mechanism, that is, the Canada Health and Social Transfer (CHST).

The aim of the national health insurance program is to ensure that all residents of Canada have reasonable access to medically necessary insured services without direct charges.

Evolution of the Act

Prior to the *Canada Health Act*, there had been two federal acts governing hospital care and medical care insurance: the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968). With the passage of these acts, Canada, for the first time, had a truly national, coast-to-coast health insurance program that covered medically necessary hospital and physician services for all residents.

The *Canada Health Act* was passed in 1984, receiving the unanimous consent of the House of Commons and the Senate. The Act replaced the two preceding acts, but retained and entrenched the criteria, or basic principles, underlying the national health insurance program that had been contained in the earlier legislation.

The most striking difference between the old acts and the new *Canada Health Act* was the addition of provisions aimed at eliminating direct charges to patients in the form of extra-billing and user charges, with respect to insured health care services. These charges are discouraged under the Act by being subject to mandatory dollar-for-dollar deductions from the federal transfer payments to the provinces and territories.

Health Care Services Covered by the Act

There are two groups of services covered by the *Canada Health Act*:

- insured health care services; and
- extended health care services.

Insured health care services are medically necessary hospital services, physician services and surgical-dental services provided to insured persons.

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in-patient and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and x-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners". Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Insured persons are eligible residents of a province, but do not include those who may be covered by other federal or provincial legislation. Persons *not* covered by the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police, inmates of federal penitentiaries, and persons covered by provincial workers' compensation. Some categories of resident, such as landed immigrants and Canadians returning to live in Canada from other countries, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health care services.

Extended health care services covered by the *Canada Health Act* are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Requirements of the Act

The *Canada Health Act* (CHA) contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

- five program criteria that apply only to insured health care services;
- two conditions that apply to insured health care services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health care services.

The Criteria

1. **Public Administration**

   This criterion applies to the health insurance plans of the provinces and territories (not to hospitals or the services hospitals provide). The health care insurance plans are to be administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions.

2. **Comprehensiveness**

   The health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners.

3. **Universality**

   One hundred percent of the insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

4. **Portability**

   Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" province during any minimum waiting period, not to exceed three months, imposed by the new province of residence. After the waiting period, the new province or territory of residence assumes health care coverage.

   Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

   The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to entitle one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

   If insured persons are temporarily absent in another province or territory, insured services are to be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

   Prior approval by one's health insurance plan may also be required before coverage is extended for elective (non-emergency) services.

5. **Accessibility**

   The health insurance plans of the provinces and territories must provide:

   - reasonable access to insured health care services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (age, health status or financial circumstances). Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
   - reasonable compensation to physicians and dentists for all the insured health care services they provide; and
   - payment to hospitals to cover the cost of insured health care services.

The Conditions

Information — the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

Recognition — the provincial and territorial governments are to appropriately recognize the federal contributions toward both insured and extended health care services.

Extra-billing and User Charges

Extra-billing — this occurs if a physician or a dentist directly charges an insured person for an insured service that is in addition to the amount that would normally be paid for by the provincial or territorial health insurance plan. For example, if a physician were to charge patients five dollars for an office visit that is insured by a health insurance plan, the five-dollar charge would be extra-billing.

User charges — these are direct charges to patients, other than extra-billing, for insured services of a province or territory's health insurance plan that are not payable, directly or indirectly, by the health insurance plan. For example, if patients were charged a fee before being provided treatment at a hospital emergency department, the fee would be considered a user charge.

Mandatory and Discretionary Penalties

Mandatory penalties — under the Extra-billing and User Charges Information Regulations of the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments. For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary penalties — breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction is based on the gravity of the default.

Consultation process — the *Canada Health Act* mandates a consultation process with the province or territory before discretionary penalties can be levied.

Health Care Services not Covered by the Act

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of services and benefits outside the scope of the Act. These additional services and benefits are provided at provincial and territorial discretion, on their own terms and conditions, and may vary from one province or territory to another. Additional services may include optometric services, dental services, chiropractic services and prescription drug benefits.

The additional services provided by the provinces and territories may be targeted to specific population groups (e.g., children or seniors), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, cosmetic surgery, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court, and cosmetic surgery.

Canada Health Act Administration

Management of the Act

This section describes the roles and responsibilities of the Canada Health Act Division as they pertain to monitoring and assessing provincial/territorial compliance with the criteria and conditions of the Act.

The Canada Health Act Division

The Division, part of the Intergovernmental Affairs Directorate, Health Policy and Communications Branch, Health Canada, administers and provides policy advice concerning the *Canada Health Act*. It monitors a broad range of sources to ensure provincial/territorial compliance with the criteria and conditions of the *Canada Health Act*, informs the Minister of possible non-compliance and recommends appropriate action. The Division also develops interpretations under the Act and provides support to legal counsel in court cases in which the *Canada Health Act* is involved.

The Division responds to inquiries about the Act and health insurance issues by telephone, internet, correspondence from the public, government departments, stakeholder organizations and the media. During fiscal year 1999-2000, it responded to more than 1,500 written and verbal inquiries.

The Division works in conjunction with Health Canada's regional offices to obtain information about developing issues, new directions, and policies in provinces and territories that may be needed for administration of the Act. A funding increase of $4 million per year to strengthen Health Canada's policy analysis and reporting capacity *vis-à-vis* the *Canada Health Act* will include an increase in staff to assist with administration of the Act in regional Health Canada offices and at headquarters.

The Division also produces the *Canada Health Act Annual Report*. Provinces and territories assist by providing information to produce the annual report in a timely manner. The Division meets with provincial and territorial officials to discuss the manner and type of information required.

Finally, the Division chairs the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing and acts as a secretariat for the Committee.

Coordinating Committee on Reciprocal Billing (CCRB)

The Committee was formed in 1991 to identify issues arising from inter-provincial/territorial billing arrangements for medical and hospital services. Committee members are also mandated to resolve administrative complexities at the operational level. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements.

The jurisdictions of Newfoundland and Labrador, Quebec, Ontario, and Alberta, and a federal chairperson, are members of the Committee. All other provinces and territories have contacts. During 1999-2000, members and contacts met once. Members discussed key issues at three additional meetings and via teleconference calls. Ongoing support was provided by the CCRB Secretariat, an operational unit within the Canada Health Act Division.

New approaches to the inter-provincial/territorial billing of in-patient rates were the focus of activities undertaken in 1999-2000. In consultation with the Canadian Institute for Health Information, the CCRB's Rate Review Working Group began development of a weighted case-costing model for in-patient services billed reciprocally between provincial/

territorial health insurance plans. Weighted case costing is used to determine the appropriate average cost of treating patients who are in hospital.

Another important area of activity involved examining and adjusting inter-provincial/territorial rates for day surgery and for various drug therapies. Rate review represents an ongoing challenge to the Committee as it keeps pace with advances in medical technology and changing costs.

A sub-committee mandated by the CCRB, reviews, updates, and provides administrative clarifications to an inter-provincial/territorial Agreement on Eligibility and Portability. This agreement was approved by the provincial/territorial ministers of health in 1971, and implemented in 1972. It is a result of cooperative and successful efforts by federal, provincial and territorial governments to set minimum standards with respect to inter-provincial/territorial eligibility and portability of health insurance programs.

Information exchanges and projects flowing from the CCRB's work demonstrate the strong federal/provincial/territorial commitment to ensuring that Canadians retain their health coverage when moving or travelling within Canada.

The Coordinating Committee on Reciprocal Billing reports to the Federal/Provincial/Territorial Advisory Committee on Health Services (ACHS). The latter consists of senior provincial/territorial officials and representatives of Health Canada. It serves as a continuing forum for consultation and information exchange on the utilization, quality, effectiveness and affordability of health services.

Health Insurance Supplementary Fund

In rare instances, individuals, through no fault of their own, have lost or been unable to obtain provincial and territorial coverage for insured health services under the *Canada Health Act*, and in accordance with the Inter-provincial/territorial Agreement on Eligibility and Portability. The Health Insurance Supplementary Fund was established pursuant to Vote L16b, *Appropriation Act No 2, 1973*, to assist these individuals. Contributions to the Fund are made by all provinces and territories in proportion to population and are matched by the federal government. The Fund, administered by the Canada Health Act Division, made no payments during 1999-2000. The balance on March 31, 2000, was $28,386.44.

Compliance with the Act

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These are the Epp letter and the federal policy on private clinics.

Interpretation - Epp Letter

Confirmation of the federal policy intent for interpretation and implementation of the *Canada Health Act* was communicated to provinces and territories in June 1985 by federal Health Minister Jake Epp. The Epp letter remains an important reference for interpretation of the Act. In the letter, the five criteria of the Act are explained as follows:

Public Administration

The overall intent of the public administration criterion is that provincial/territorialhealth care insurance plans be administered by a public authority, accountable to the provincial/ territorial government for decision-making on benefit levels and services. This authority's records and accounts must be publicly audited.

Comprehensiveness

Under the comprehensiveness criterion, hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As well, medically necessary physician services rendered by licensed medical practitioners and surgical-dental procedures that require a hospital for proper performance must be covered by provincial/ territorial health insurance plans.

The letter also stated that provinces and territories, along with medical professionals, have the prerogative and responsibility for interpreting which physician services are medically necessary. As well, provinces and territories determine which hospitals and hospital services are required to provide acute, rehabilitative and chronic care.

Universality

The intent of the universality criterion of the CHA is to ensure that all bona-fide residents of all provinces and territories are entitled to coverage and to benefits under provincial/ territorial health insurance plans. Eligible residents have the option of not participating in a plan.

Provinces and territories have the right to levy taxes. Therefore, a premium scheme *per se* is not precluded by the Act, provided that the provincial/territorial health care insurance plan is operated and administered in a manner that does not deny coverage or prevent access to necessary hospital and physician services to bona-fide residents of a province or territory. Administrative arrangements should be such that residents are not denied or do not forego coverage by reason of an inability to pay premiums.

Portability

The intent of the portability provision of the CHA is to provide insured persons continuing protection under their provincial/territorial health care insurance plans when they are temporarily absent from their province or territory of residence or when moving from province or territory to province or territory. While temporarily in another province/territory of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Health care providers should be assured of reasonable levels of payment in respect of the cost of those services.

For services received outside of Canada, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces.

Accessibility

Under the accessibility criterion, the CHA seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services.

The *Canada Health Act* also requires that provincial/territorial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users.

The Epp letter also states that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial/territorial governance of the institutions and professions that provide insured services to users.

With regard to CHA conditions relating to recognition of federal contributions and the provision of information, the Epp letter states that the federal government will rely on the goodwill of provincial/territorial ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995. Her letter provided the federal interpretation of the *Canada Health Act* as it related to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics that also receive funding for these services from provincial/territorial health insurance plans. The letter states that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

In her January 6, 1995 letter, Minister Marleau set October 15, 1995 as the date on which penalties would begin. A period of more than nine months was provided to give provinces and territories enough time to make the necessary adjustments to their policy/regulatory frameworks and thereby avoid penalties.

Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995. These penalties took the form of deductions from monthly cash transfer payments. Under the Act, deductions are calculated based on estimates provided by provinces and territories pursuant to the *Canada Health Act* Extra-Billing and User Charges Information Regulations. Where such estimates are not submitted, the *Canada Health Act* allows the federal minister of health to estimate the amount of user charges that have been imposed on residents of the non-compliant province or territory as a basis for the penalties.

The federal government remains committed to the principles of the *Canada Health Act* while providing provinces and territories with the flexibility to deliver medically necessary services in the most appropriate setting and manner. It is acknowledged that private clinics that provide medically necessary services can do so efficiently and effectively. This policy does not prevent them from existing. The policy is intended to ensure that medically necessary services being provided in private clinics are fully covered by provincial/territorial plans.

Enforcement Activities

Guided by the Epp letter and the federal policy on private clinics, *Canada Health Act* enforcement activities are conducted as follows:

The goal in administration of the *Canada Health Act* is to work collaboratively to maintain and achieve provincial/territorial compliance with the principles of the Act. When issues related to possible non-compliance are identified, they are often resolved efficiently at the officials level without penalties being imposed. This reflects the fact that the federal and provincial/territorial governments are mutually committed to the principles of the *Canada Health Act*.

The *Canada Health Act* also prescribes a consultation process in the case of compliance concerning the criteria or information and visibility conditions. In the event that the federal minister is of the opinion that a provincial/territorial plan does not satisfy any one of the criteria or the information and visibility conditions, reductions to federal contributions may be made. Prior to referring the matter to

the Governor in Council, the Minister must notify the province or territory, seek clarification from the province or territory, report on the findings, and, if requested by the provincial/territorial health minister, meet to discuss the matter. Only upon satisfaction of the Governor in Council that the province or territory has ceased to satisfy any of the criteria or conditions may an order be issued to reduce or withhold cash contributions.

Penalty Provisions of the Act

Extra-Billing and User Charges Provisions

Provisions for extra-billing and user charges are outlined in sections 18 to 21 of the *Canada Health Act*. The Act stipulates that a province or territory may only qualify for a full cash contribution for insured health services if no payments under the provincial/territorial plan have been subject to extra-billing. Additionally, the province or territory must not permit user charges for insured health services under the plan, except as provided for under subsection 19(2) respecting persons who require chronic care and who are more or less permanently residing in a hospital or other institution. If it has been determined that either extra-billing or user charges, or both, exist in a province or territory, then a mandatory deduction is to be made from the federal cash contribution. The amount of such a deduction for a fiscal year is an amount that, on the basis of information provided by the province or territory in accordance with the Extra-Billing and User Charges Information Regulations, the federal minister of health determines to have been charged through extra-billing or user charges. Where a province or territory does not provide the information according to the Regulations, the amount of the deduction is an amount that the Minister estimates to have been so charged pursuant to subsections 20(1), 20(2) and 20(3) of the *Canada Health Act*.

Extra-Billing and User Charges Information Regulations

Pursuant to the Extra-Billing and User Charges Information Regulations, provinces and territories are required to submit estimates on extra-billing and user charges expected to be charged for insured services prior to the beginning of each fiscal year, as well as statements showing the aggregate amount actually charged with respect to both. The purpose of obtaining statements from the provinces and territories is to verify and confirm that the amounts deducted on the basis of the estimates provided are accurate. Adjustments are allowable.

Call letters from Health Canada are sent to provincial and territorial health ministers each year in accordance with the Extra-Billing and User Charges Information Regulations. The estimates submitted by each province and territory are used to advise the Minister on whether provinces and territories are entitled to the full cash transfer payment for the fiscal year in question under the Canada Health and Social Transfer (CHST), and to assist in determining the level of monthly deductions, if required.

According to the Extra-Billing and User Charges Information Regulations, estimates of extra-billing and user charges must be provided to Health Canada by provinces and territories before April 1 of the fiscal year to which they relate.

With the exceptions of Nova Scotia and Ontario, all provinces and territories provided a nil estimate for 1999-2000. Ontario indicated in its response that it estimated $9,000 would be charged in respect of insured services through extra-billing. However, their letter also confirmed that regardless of the amount extra-billed, the Ministry of Health would recover all

amounts charged where extra-billing had been confirmed. The latter is prohibited under the *Health Care Accessibility Act* in that province. As for Nova Scotia, it estimated that $57,375 in user charges would be charged to patients for services at a private clinic in that province.

Discretionary Penalty Provisions

Discretionary penalty provisions are outlined in sections 14 to 17 of the *Canada Health Act*. On the recommendation of the Minister of Health, the Governor in Council may reduce the amount transferred to a province or territory, or withhold the entire amount, depending on the gravity of the default under the Act.

Once the Minister of Health has identified a possible breach of the criteria or conditions, a process is followed, as specified in the Act. Before referring the matter to the Governor in Council, a notice of concern must be sent by registered mail to the Minister responsible for health care in the particular province or territory. This letter provides the province or territory with official notice that a *Canada Health Act* concern exists with respect to the delivery of insured health services in that province or territory.

The federal minister of health must then undertake bilateral discussions with the province or territory to seek additional information with respect to the problem and must report to the province or territory within 90 days of sending the notice of concern. The province or territory is then entitled to meet with the Minister to discuss the report, within a reasonable time frame.

Further action is not needed if, during consultation, the province or territory resolves to remedy the breach within a reasonable period that the Minister finds satisfactory. If the Minister is of the opinion that consultation is not possible, the Minister may act without such consultation. If an acceptable solution cannot be arrived at, the Minister refers the issue for consideration of the Governor in Council who may authorize that a reduction of the payment be made or that the entire Canada Health and Social Transfer (CHST) be withheld. Following consultation with the minister of health in the affected province or territory, the penalty imposed can be reimposed in successive fiscal years, as long as the situation continues to be unresolved.

To date, the discretionary penalty provisions of the Act have never been applied.

History of Deductions

Penalties Since the Passage of the *Canada Health Act*

Penalties that have been levied to date fall into three intervals. During the period 1984 to 1987, total deductions of $246,732,000 were withheld from seven provinces that permitted user charges and/or extra-billing. Subsection 20(5) of the *Canada Health Act* provided a "grace" period to allow provinces and territories sufficient time to comply with the extra-billing and user charges provisions of the Act. Therefore, deductions in respect of these charges would be returned to the province or territory if the charges were eliminated before April 1, 1987. A province or territory that ended extra-billing and user charges within three years of the coming into force of the Act, that is, before April 1, 1987, was entitled to have the total amount of deductions refunded. In 1986-1987, all provinces and territories became eligible and all deductions made during the 1984-1987 period were refunded.

The second period of deductions related to extra-billing in British Columbia during the period 1992-1995. These non-refundable deductions totaling $2.025 million ended when the *Medicare Protection Act*, introduced by British Columbia in June 1995, came into effect on September 30, 1995, banning extra-billing by physicians participating in British Columbia's Medical Services Plan.

Prior to the third interval, related to deductions under the federal policy on private clinics, provinces and territories were given until October 15, 1995 to regulate private clinics and end direct charges to patients for medically necessary services. In November 1995, as authorized in the Extra-billing and User Charges Information Regulations of the *Canada Health Act* and in accordance with the federal policy on private clinics, the Government of Canada again deducted from federal transfer payments to Newfoundland and Labrador, Nova Scotia, Manitoba, and Alberta for charging facility fees to patients for medically necessary services at private clinics. The deductions to Alberta ended in July 1996, those to Newfoundland and Labrador ended on January 1, 1998, and Manitoba's deductions ended on January 1, 1999. Deductions to Nova Scotia are still being made in the amount of $4,780 per month.

Tables 1 and 2 itemize deductions by province or territory since the passage of the *Canada Health Act*.

Investigations into Potential Non-compliance Activities

Health Canada's approach to resolving possible non-compliance issues emphasizes transparency, consultation and dialogue. In most instances, issues are resolved through consultation and discussion based on a thorough examination of the facts. Penalties are only applied when other means of resolving issues have failed.

It has been the federal government's policy to resolve issues of non-compliance by working collaboratively with the provinces/territories on an informal basis. The federal government has also provided assessments of provincial/territorial initiatives when requested to do so and has worked collaboratively on policy interpretations. This has been accomplished through a number of resolution mechanisms, including the Federal/Provincial/Territorial Conference of Ministers/Deputy Ministers of Health; existing federal/provincial/territorial advisory committees and/or ad-hoc committees; and other bilateral/multilateral meetings, discussions and negotiations.

To date, almost all disputes and issues related to the administration and operation of the *Canada Health Act* have been addressed and resolved without resorting to penalties. One example is Prince Edward Island's denial of health insurance plan registration to residents without social insurance numbers.

During 1999-2000, Health Canada initiated investigations on three specific issues. All of these matters are still being pursued.

Quebec - Allegations of Facility Fee Charges

Following media reports, the Quebec government launched an investigation into claims that a private clinic in Montreal charged patients directly for use of operating rooms to perform medical procedures, and then billed the *Régie de l'assurance-maladie du Québec* for the medical service.

The facility fees that were reportedly charged to patients would be considered user fees under the *Canada Health Act* and the federal policy on private clinics.

The Régie de l'assurance-maladie du Québec is investigating this issue. Health Canada is awaiting details from the Ministère de la Santé et des Services sociaux du Québec about the status of the investigation.

Ontario - Allegations of Queue Jumping for Magnetic Resonance Imaging Services

In December 1999, Health Canada became aware that individuals had purchased MRI services in a public hospital by going directly to Ontario MRI, a private company that contracts with public hospitals to provide uninsured MRIs (i.e., provided for third-party payers). Ontario legislation prohibits anyone being charged for medically necessary services. Health Canada has requested that the Ontario Ministry of Health and Long-Term Care confirm that no insured persons are being charged for MRI services.

Alberta - Allegations of Queue Jumping and Extra Charges for Cataract Surgery

In January 2000, the Consumers Association of Canada (Alberta chapter) alleged that patients purchasing enhanced services at private clinics received quicker access to cataract surgery. There was also an allegation by the media that an individual had jumped the queue for cataract surgery by paying for a refractive lensectomy—a service not insured by the Alberta Health Care Insurance Plan—during which the person's cataracts were removed.

The Alberta government asked the College of Physicians and Surgeons of Alberta to advise on whether a refractive lensectomy, when performed on a person who has clinically significant cataracts, is in substance cataract surgery. Health Canada will review the College's response, when available, and ascertain the course of action planned by Alberta Health and Wellness.

Table 1 — Annual Deductions by Province and Territory Since Passage of the *Canada Health Act*

(in thousands of dollars)

Province/ Territory	1984-85*		1985-86*		1986-87*		1987-1992		1992-93		1993-94		1994-95	
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges
Newfoundland and Labrador							There were no deductions during this period.							
Prince Edward Island														
Nova Scotia														
New Brunswick	63	3,015	84	3,222	206	296								
Quebec		7,893		6,139										
Ontario	39,996		55,328		13,332									
Manitoba	810		460											
Saskatchewan	1,451		656											
Alberta	8,109	1,827	9,216	2,640	5,878	1,362								
British Columbia		22,797		30,620		31,332			83		1,223		676	
Yukon														
Northwest Territories														
Nunavut														
Annual Totals	50,429	35,532	65,744	42,621	19,416	32,990			83		1,223		676	

* Reimbursed, as permitted by the *Canada Health Act*, for deductions made in the period 1984-85 to 1986-87.

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Table 1 — Annual Deductions by Province and Territory Since Passage of the *Canada Health Act* (cont'd)

(in thousands of dollars)

Province/ Territory	1995-96		1996-97		1997-98		1998-99		1999-2000		TOTAL 1984-85 to 1999-2000		
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Total
Newfoundland and Labrador		46		96		128		53				323	323
Prince Edward Island													
Nova Scotia		32		72		57		39		57		257	257
New Brunswick											353	6,533	6,886
Quebec												14,032	14,032
Ontario											108,656		108,656
Manitoba		269		588		587		612			1,270	2,056	3,326
Saskatchewan											2,107		2,107
Alberta		2,319		1,266							23,203	9,414	32,617
British Columbia	43										2,025	84,749	86,774
Yukon													
Northwest Territories													
Nunavut													
Annual Totals	43	2,666		2,022		772		704		57	137,614	117,364	254,978

Table 2 — Summary of Deductions by Province and Territory Since Passage of the *Canada Health Act*

(in thousands of dollars)

Province/ Territory	Total Deductions Made 1984-85 to 1999-2000			Reimbursements Made for the Period 1984-85 to 1986-87*			Net Deductions for the Period 1984-85 to 1999-2000		
	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total
Newfoundland and Labrador		323	323					323	323
Prince Edward Island									
Nova Scotia		257	257					257	257
New Brunswick	353	6,533	6,886	(353)	(6,533)	(6,886)			
Quebec		14,032	14,032		(14,032)	(14,032)			
Ontario	108,656		108,656	(108,656)		(108,656)			
Manitoba	1,270	2,056	3,326	(1,270)		(1,270)		2,056	2,056
Saskatchewan	2,107		2,107	(2,107)		(2,107)			
Alberta	23,203	9,414	32,617	(23,203)	(5,829)	(29,032)		3,585	3,585
British Columbia	2,025	84,749	86,774		(84,479)	(84,749)	2,025		2,025
Yukon									
Northwest Territories									
Nunavut									
Annual Totals	137,614	117,364	254,978	(135,589)	(111,143)	(246,732)	2,025	6,221	8,246

* Reimbursed, as permitted by the *Canada Health Act*, for deductions made in the period 1984-85 to 1986-87.

Table 1 — Annual Deductions by Province and Territory Since Passage of the *Canada Health Act* (cont'd)

(in thousands of dollars)

Province/ Territory	1995-96		1996-97		1997-98		1998-99		1999-2000		TOTAL 1984-85 to 1999-2000		
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Total
Newfoundland and Labrador		46		96		128		53				323	323
Prince Edward Island													
Nova Scotia		32		72		57		39		57		257	257
New Brunswick											353	6,533	6,886
Quebec												14,032	14,032
Ontario											108,656		108,656
Manitoba		269		588		587		612			1,270	2,056	3,326
Saskatchewan											2,107		2,107
Alberta		2,319		1,266							23,203	9,414	32,617
British Columbia	43										2,025	84,749	86,774
Yukon													
Northwest Territories													
Nunavut													
Annual Totals	43	2,666		2,022		772		704		57	137,614	117,364	254,978

Table 2 — Summary of Deductions by Province and Territory Since Passage of the *Canada Health Act*

(in thousands of dollars)

Province/ Territory	Total Deductions Made 1984-85 to 1999-2000			Reimbursements Made for the Period 1984-85 to 1986-87*			Net Deductions for the Period 1984-85 to 1999-2000		
	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total
Newfoundland and Labrador		323	323					323	323
Prince Edward Island									
Nova Scotia		257	257					257	257
New Brunswick	353	6,533	6,886	(353)	(6,533)	(6,886)			
Quebec		14,032	14,032		(14,032)	(14,032)			
Ontario	108,656		108,656	(108,656)		(108,656)			
Manitoba	1,270	2,056	3,326	(1,270)		(1,270)		2,056	2,056
Saskatchewan	2,107		2,107	(2,107)		(2,107)			
Alberta	23,203	9,414	32,617	(23,203)	(5,829)	(29,032)		3,585	3,585
British Columbia	2,025	84,749	86,774		(84,479)	(84,749)	2,025		2,025
Yukon									
Northwest Territories									
Nunavut									
Annual Totals	137,614	117,364	254,978	(135,589)	(111,143)	(246,732)	2,025	6,221	8,246

* Reimbursed, as permitted by the *Canada Health Act*, for deductions made in the period 1984-85 to 1986-87.

Federal Contributions and Payments

The *Canada Health Act* sets the criteria and conditions, with respect to insured health services and extended health care services, that must be met by provincial/territorial health care insurance plans before a full cash contribution can be made. This section describes the evolution of federal funding arrangements in support of these services and identifies cash deductions made in fiscal year 1999-2000.

Federal/Provincial/Territorial Health Financing Arrangements

Since the federal government began contributing to provincial/territorial health insurance programs in 1957, the arrangements for these contributions have evolved. Prior to 1977, the federal government cost shared hospital and physician services with the provinces and territories. In 1977, cost sharing was replaced by block funding (Established Programs Financing - EPF). Then, on April 1, 1996, the Canada Health and Social Transfer (CHST) replaced the EPF and the Canada Assistance Plan (CAP) and continues to provide support through both cash and tax transfers for health and other social programs provided by the provinces and territories. These arrangements are described in the following section. Further information of federal fiscal programs and arrangements are available from the Department of Finance.

Cost Sharing

Originally, the federal government's method of contributing to provincial/territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the aggregate operating costs. Under the *Medical Care Act* (1968), the federal contribution in support of medical care was also based on half the national per capita cost of the insured services, multiplied by the number of insured persons in each province and territory.

Established Programs Financing (EPF)

In 1977, cost sharing arrangements were replaced by Established Programs Financing. Unlike the previous cost sharing arrangements, EPF was a block-funding system, no longer open-ended, although funding was from the start and for most of EPF history, tied to economic growth under various formulae.

Under EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. Except for the first few years, the provinces and territories received equal per capita funds (cash plus tax transfers).

The transfer of income tax points gave the provinces and territories the benefits of taxation that would otherwise have accrued to the federal government. Provinces and territories could collect taxation revenues to support health and post-secondary education.

Tax transfers were based on the value of income tax points transferred by the federal government to the provinces and territories (13.5 personal income tax points and one corporate income tax point).

For most of EPF's history, the cash component was determined as a residual. The provincial/territorial cash figure was arrived at after subtracting the total tax transfer from the total per capita entitlement. Cash consisted of "insured health services" (medically necessary hospital and medical services) and "extended health care services." The latter was distributed

on an equal per capita basis. Cash funds were transferred monthly to each province and territory, provided the provincial/territorial plan satisfied the criteria and conditions set out in the *Canada Health Act*.

In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion total EPF entitlements (cash and tax), 71.2 percent of which was intended for health care and the rest for post-secondary education. On April 1, 1996, EPF and the Canada Assistance Plan (cost sharing plan for social services/assistance programs) were replaced by the Canada Health and Social Transfer.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced the Canada Health and Social Transfer, which came into effect April 1, 1996. At that time, provinces and territories received the same share of the CHST that they had received under the Canada Assistance Plan (CAP), and health and post-secondary education funding made under Established Programs Financing. The provincial and territorial distribution that existed under the previous programs was carried over into the CHST.

The CHST replaced the previous transfers under EPF and CAP. The CHST is a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments in support of health, post-secondary education, and social services/ assistance programs.

For fiscal year 1999-2000, CHST payments amounted to $29.4 billion in the form of tax point transfers and cash contributions (October 2000 estimates).

Making CHST Payments

The Department of Finance has been responsible for making CHST payments to the provinces and territories since April 1, 1996. However, the Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance in advance of the payment dates. The Department of Finance then makes the actual deductions from the twice-monthly CHST payments to the provinces and territories.

1999-2000 Deductions

During 1999-2000, CHST deductions were made in respect of user charges to only one province: Nova Scotia. A total of $57,360 was deducted from Nova Scotia's CHST cash entitlement.

Provincial/Territorial Health Insurance Plans

During 1999-2000, provincial and territorial health insurance plans continued to provide access to a comprehensive range of hospital, physician and extended health care services.

In most provinces and territories, new measures related to the supply of health human resources, particularly physicians and nurses, were announced or implemented.

These measures include recruitment and retention strategies for physicians; an increased number of training positions for medical students; enrichment of bursary programs for undergraduate medical students and medical residents; improvements to rural practice enhancement training programs, and new funding for additional nursing positions.

Provincial and territorial authorities also took steps in 1999-2000 to improve access to insured hospital services. These measures include the opening of new acute and chronic care beds; resources to address waiting lists for medical treatments, surgeries and cancer treatments; the purchase and installation of new high-tech diagnostic equipment, such as magnetic resonance imaging (MRI) and computed tomography (CT); and expansion of telehealth services.

All provinces and territories provide a range of health services that go beyond the requirements (criteria) of the *Canada Health Act*. These additional benefits include programs such as pharmacare, home care, ambulance services, and aids to independent living. Such services and benefits are provided at provincial and territorial discretion, and on their own terms and conditions.

The following section presents the 13 provincial and territorial health insurance plans that make up the Canadian health insurance system. The purpose of the section is to demonstrate the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* program criteria and conditions in 1999-2000.

The information contained in this section has been supplied by the provinces and territories. In order to help ensure consistency and thoroughness, provincial/territorial submissions have been prepared according to a template that Health Canada discussed with representatives in each province and territory. Officials were asked to provide narrative descriptions of their health insurance plans according to the program criteria areas of the *Canada Health Act*. In addition, provinces and territories were asked to describe how their governments met the *Canada Health Act* requirement for recognition of federal contributions in support of insured and extended health care services. Finally, provincial and territorial officials were asked to describe the range of extended health care services provided in their jurisdiction; where extended health care includes nursing home intermediate care services, adult residential care services, home care services, and ambulatory health care services.

Please note that the description of Quebec's health insurance plan was submitted according to the format used in previous editions of the *Canada Health Act* Annual Report. Quebec chose not to submit its information in the manner and detail requested by Health Canada, as noted in a preface to Quebec's narrative.

In addition to the provincial and territorial plan descriptions that follow, all jurisdictions other than Quebec have submitted statistical data on the cost and utilization of insured hospital and medical services as part of a new annex found at the back of this publication. Details are shown for services that were received within a person's province or territory of residence as well as services that were received in other jurisdictions and outside Canada.

Program Criteria

The *Canada Health Act* has five program criteria.

Public Administration (CHA, section 8)

The first criterion is public administration. This requires that provincial/territorial health care insurance plans be administered and operated on a non-profit basis, by public authorities responsible to the provincial or territorial governments, and subject to audits of their accounts and financial transactions.

Subsection 1.0 of each provincial/territorial narrative relates to the public administration criterion. The elements of this subsection include the name of the health care insurance plan and the public authority responsible for operating and administering the plan, a description of the reporting relationship that exists between the provincial/territorial minister of health and the public authority responsible for each plan, and a summary of the auditing process in place for reviewing the financial accounts and transactions of the plan.

Comprehensiveness (CHA, section 9)

The second criterion of the *Canada Health Act* is comprehensiveness. This criterion requires that the provincial/territorial health care insurance plans provide coverage for all medically necessary hospital services, and medically required services rendered by medical practitioners. The Act also requires that coverage be provided for any medically or dentally required surgical-dental procedure performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure.

Information on the comprehensiveness of provincial and territorial health care insurance plans is covered in subsection 2.0 of each narrative. Included here are changes made to insured services legislation during 1999-2000, details on the range of insured services covered by each plan and the possibility for such services to be provided outside of the plan, and details of services provided by hospitals, physicians and dentists that are not covered by the public health insurance plans.

Universality (CHA, section 10)

The third criterion is universality. This requires that provincial/territorial health care insurance plans entitle all insured persons in the province or territory to the insured services provided, on uniform terms and conditions.

Universality is reported in subsection 3.0 of each provincial/territorial narrative. This includes information on health care plan eligibility requirements, registration requirements, details of health care premiums where applicable, and information on coverage for any special categories of individual, such as foreign students, temporary workers, and refugees.

Portability (CHA, section 11)

The fourth criterion is portability. This requires that provincial/territorial health care insurance plans not impose any minimum period of residence in the province or territory, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period, imposed by the health care insurance plan of another province or territory.

Subsection 4.0 of each narrative provides a description of the portability parameters in that jurisdiction.

Accessibility (CHA, section 12)

The fifth criterion is accessibility. It requires that provincial/territorial health care insurance plans provide access to insured health services on uniform terms and conditions in a manner that does not impede or preclude reasonable access to services by insured persons. In addition, the plans must pay for insured services in accordance with a tariff or system of payment authorized by the law of the province or territory. The plans must also provide reasonable compensation for all insured health services rendered by medical practitioners and dentists, and must pay hospitals for the cost of insured services.

Subsection 5.0 reports on accessibility. Details include hospital services and resources in each jurisdiction (beds, nurses, other health professionals, medical, surgical, rehabilitative and diagnostic equipment), a description of measures taken by the jurisdiction in 1999-2000 to improve access to insured hospital services and reduce waiting times, and a description of physician availability and measures taken to improve access to physician services.

Program Condition

The *Canada Health Act* requires that provinces and territories give recognition to the Canada Health and Social Transfer in any public documents, advertisements or promotional material concerning insured health services and extended health services in the province or territory. Subsection 6.0 of each provincial/territorial narrative provides a description of how that jurisdiction reported on the Canada Health and Social Transfer in 1999-2000.

Extended Health Care Services

The *Canada Health Act* defines "extended health care services" as nursing home intermediate care services; adult residential care services; home care services; and ambulatory health care services.

Subsection 7.0 of each provincial and territorial plan description gives details of both insured and non-insured services such as public nursing home facilities, home care and support services, residential care services, ambulatory health care, long term care centres, and mental and psychiatric health services. Several provinces and territories have provided details of insured services that go beyond the basic requirements of the *Canada Health Act*.

Newfoundland and Labrador

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department of Health and Community Services include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and all transactions are audited by the Auditor General of the Province.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act provides that the Minister may make regulations for the provision of insured services upon uniform terms and conditions to residents of the Province under the conditions specified in the *Canada Health Act* and Regulations made under that Act. Governing regulations include the Hospital Insurance Regulations.

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999 and came into force on April 1, 2000. This Act replaced the *Medical Care Insurance Act*, which was previously in effect. Essentially, the new act discontinued the Medical Care Commission previously responsible for the administration of the MCP with Plan resources being integrated with the Department of Health and Community Services.

The mandate of the MCP is to administer the medical care insurance program on behalf of the residents of Newfoundland and Labrador.

The MCP is responsible for facilitating the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures, and systems that permit appropriate compensation to providers for their rendering of insured professional services.

The MCP operates in accordance with the provisions of the *Medical Care Insurance Act*, (1999) and Regulations, and in compliance with the criteria of the *Canada Health Act*.

1.2 Reporting Relationship

An annual MCP report is submitted to the Minister on or before the 30th day of September of each calendar year. The annual report is then submitted to the House of Assembly within 10 sitting days of the House opening.

1.3 Audit of Accounts

Each year, the Province's Auditor General performs an independent examination of the financial statements of the MCP. The Auditor General has full and unrestricted access to the MCP records.

A copy of the most recent Auditor General's report is included in the MCP's annual report. Hospital boards are subject to Financial Statement Audits, Reviews, and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the Boards under the terms of the *Public Tendering Act*. Review engagements and Compliance Audits are carried out by personnel from the Department of Health and Community Services. Physician audits are performed by personnel from the Department of Health and Community Services under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records are reviewed to ensure that the record supports the service billed and that the service is insured under the Medical Care Plan.

Beneficiary audits are performed by personnel from the Department of Health and Community Services under authority of the Newfoundland *Medical Care Insurance Act* (1999). Individuals are randomly selected on a biweekly basis.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* and Regulations provides for insured hospital services in Newfoundland and Labrador. Insured hospital services are mainly provided in 34 facilities throughout the Province. Insured in-patient services include accommodation and meals at the standard level; nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologics and related preparations; medical and surgical use of operating room, case room and anaesthetic facilities; and rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology).

Insured out-patient services include laboratory, radiological and other diagnostic procedures; rehabilitative services; out-patient and emergency visits; day surgery; drugs, biologicals and related preparations medically necessary when administered in hospital.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the same as that referred to in section 1.1 of the *Medical Care Insurance Act* (1999), which was amended in December, 1999. The sole purpose of the amendment was to deal with housekeeping issues created by the de-commissioning of the MCP and integration with the Department of Health and Community Services.

Other governing legislation under the Medical Care Insurance Act includes:

- the Medical Care Insurance Insured Services Regulations;
- the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- the Medical Care Insurance Physician and Fee Regulations.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan in Newfoundland and Labrador. A physician must be licensed to practice in the Province by the Newfoundland Medical Board.

In 1999-2000, 840 fee-for-service physicians provided fee-for-service insured services in the province.

Physicians can opt out of the health care insurance plan as outlined in section 12 of the *Medical Care Insurance Act*, 1999, namely:

"Where a physician providing insured services is not a participating physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

- before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and
- provide the beneficiary to whom the physician has provided the insured service with the information required by the Minister to enable payment to be made under this Act to the beneficiary in respect of the insured service".

As of March 31, 2000, there were no non-participating physicians in the Province.

For purposes of application of the Act, the following services are covered:

- all services properly and adequately provided by physicians to beneficiaries who are suffering from an illness requiring medical treatment or advice;
- group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and regulations made under that Act.

There are no limitations on the services covered, provided the services qualify under one or more of the conditions listed above.

No services were added in 1999-2000 to the list of insured physician services covered by the health care insurance plan in Newfoundland and Labrador.

Ministerial direction is required to add a physician service to the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial Medical Association. Public consultation is involved.

2.3 Insured Surgical-Dental Services

Surgical-dental treatments properly and adequately provided to a beneficiary and carried out in a hospital by a dentist are covered by the MCP if the treatment is of a type specified in the surgical-dental services Schedule.

All dentists, licensed to practice in Newfoundland and Labrador and who have hospital privileges, are allowed to provide surgical-dental services. The dentist's licence is issued by the Newfoundland Dental Licensing Board.

Dentists can opt out of the Plan. The Dentists must advise the patient of their opted out status, stating the fees expected, and providing the patient with a written record of services and fees charged. One dentist is currently in an opted out category.

Addition of a surgical-dental service to the list of insured services must be approved by the Department of Health and Community Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include preferred accommodation at the patient's request; cosmetic surgery and other services deemed to be medically unnecessary; ambulance or other patient transportation prior to admission or upon discharge; private duty nursing arranged by the patient; non-medically required x-rays or other services for employment or insurance purposes; drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital; bedside telephones, radios or television sets for personal, non-teaching use; fibreglass splints; services covered by Workers' Compensation legislation or by other federal or provincial legislation; and services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board. The use of the hospital setting for any services deemed not insured by the Medicare Plan would also be uninsured under the Hospital Insurance Plan.

For purposes of application of the *Medical Care Insurance Act*, 1999 the following is a list of non-insured physician services:

- any advice given by a physician to a beneficiary by telephone;
- the dispensation by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for or on behalf of, or any communication to or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of transportation of patients;
- acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosis of the illness proposed to be treated by acupuncture;
- examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;
- plastic or other surgery for purely cosmetic purposes unless medically indicated;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for the purpose of determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner, for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma;
- circumcision of newborns;
- Hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside of Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the province at a facility not approved by the Newfoundland Medical Board;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- *in-vitro* fertilization and OSST (ovarian stimulation and sperm transfer);
- reversal of previous sterilization procedure;
- surgical diagnostic or therapeutic procedures not provided on the coming into force of this paragraph in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
- other services not within the ambit of section 3.

All diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the Province. Hospital policy on access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practice. Patients retain the right to financially upgrade the standard medical goods or service. Standards for medical goods are developed by the hospitals providing those services in consultation with providers of the service.

Surgical-dental and other services not covered by the Children's Health Plan are the dentist's, oral surgeon's or general practitioner's fees for routine dental extractions in hospital, and fluoride dental treatment for children under four years of age.

3.0 Universality

3.1 Eligibility

Newfoundland and Labrador residents are eligible for coverage under the provincial health care program.

The *Medical Care Insurance Act*, (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Province, but does not include tourists, transients or visitors to the Province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations identify those residents eligible to receive coverage under the Plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the Plans include:

- students and their dependents already covered by another province or territory;
- dependents of residents if covered by another province or territory;
- certified refugees and refugee claimants and their dependents;
- foreign workers with Employment Authorizations and their dependents who do not meet the established criteria;
- foreign students and their dependents;
- tourists, transients and visitors and their dependents;
- Canadian Armed Forces and Royal Canadian Mounted Police personnel;
- inmates of federal prisons; and
- armed forces personnel of other countries stationed in the Province.

3.2 Registration Requirements

Registration under the Medical Care Plan and possession of a valid Medical Care Plan card are required in order to access insured services.

New residents are advised to apply for coverage as soon as possible upon arrival in Newfoundland and Labrador.

It is the parent's responsibility to register a newborn or adopted child. Parent(s) of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from the parent's.

Applications for coverage for an adopted child will require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the Department of Health and Community Services. Applications for coverage for a child adopted outside Canada will require Landed Immigrant documents for the child.

As of March 1, 2000 there were a total of 618,118 active beneficiaries registered with the Medical Care Plan.

3.3 Other Categories of Individual

Foreign workers and clergy, and dependents of NATO are eligible for benefits. Holders of Minister's Permits are also eligible, subject to Plan approval.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage as of the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage as of the day of arrival. The same applies to discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the Medical Care Plan. Immediate coverage is provided to persons from outside Canada who are authorized to work in the Province for one year or more.

4.2 Coverage During Temporary Absences In Canada

Coverage is provided to provincial residents during temporary absences within Canada. The Province has entered into formal agreements with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing arrangement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province at least four consecutive months in each 12 month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include:

- prior to leaving the Province for extended periods, persons must contact the MCP to obtain an out-of-province coverage certificate;
- beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate for up to 12 months' coverage. Upon return, beneficiaries are required to reside in the Province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months' coverage;
- students leaving the Province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located out of the Province;
- persons leaving the Province for employment purposes may receive a certificate for up to 12 months' coverage. Verification of employment may be required;
- persons must not establish residency in another province, territory, or country while maintaining coverage under the Newfoundland Medical Care Plan;
- for out-of-province trips lasting 30 days or less, a certificate is not required, but will be issued upon request;
- for out-of-province trips lasting more than 30 days, a certificate is required. This would serve as proof of a resident's ability to pay for services while out of the province; and
- failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the Province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to provincial residents during temporary absences outside Canada. Out-of-country insured hospital in-patient and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. The maximum amount payable by the government's hospitalization plan for out-of-country in-patient hospital care is $350 per day if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness, and are also insured for elective services, when they are not available in the Province or within Canada. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in a province in which they are available.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals and/or licensed physicians in the other provinces and territories.

If a resident of the Province has to seek specialized hospital care outside the country because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department of Health and Community Services. The referring physicians must contact the Department and/or the Medical Care Plan for prior approval.

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the Plan so that patients may be made aware of any financial implications. General practitioners and specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the Province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for hospital services and no extra-billing by physicians in the Province.

5.2 Access to Insured Hospital Services

Insured hospital services are mainly provided in 34 facilities throughout the provinces. The total number of practising registered nurses in the Province is 5,447. Approximately 85 percent of the most recent graduates choose to remain in the Province with the availability of a signing bonus of $3,000.

Access to beds have been affected in some areas of the Province where shortages of nurses exist, particularly urban acute care services. These shortages contributed to summer bed closures increasing by 16 percent in 2000 over last year. Nurse practitioner positions have increased to approximately 35, which improves public access to primary health care. Shortages in other professional groups exist particularly in allied health groups such as physiotherapy, speech language pathology, audiology and occupational therapy, as well as radiation therapists. Focused recruitment and incentive programs are in place and new approaches continue to be developed.

Recruitment initiatives are a continuous process for most professional groups. With the movement of physicians and some allied health professionals in and out of the Province, there have been fluctuations in accessibility to some insured services during the year.

In late 1999-2000 the provincial government approved $15 million for high-priority capital equipment needs. This includes four additional CAT scanners to improve geographic access and reduce patient wait times. Replacement of other equipment in critical patient service areas e.g., diagnostic imaging, laboratory, emergency, operating room and intensive coronary care will improve patient access throughout and reduce the number of patient cancellations due to equipment breakdowns.

To reduce patient wait times for cardiac surgery, a limited number of patients were referred to out-of-province facilities during the fall and winter of 1999-2000.

5.3 Access to Insured Physician and Dental-Surgical Services

The number of physicians practising in the Province is relatively stable. The Department of Health and Community Services is working with regional health boards to develop a human resource plan for physicians based on the principle of access, reflective of geography, numbers, distance to travel, etc. Physician supply reports are being produced, and include information such as average age of physician groups, etc.

Improvement in salary scale and retention bonuses for salaried physicians reflective of geography have been implemented to improve rural recruitment. Premiums on hospital-based services by general practitioners in rural hospitals have also been applied.

Service levels and accessibility (wait times) issues are monitored by regional health boards with adjustments made as required, such as increasing the number of cardiac surgeries performed weekly.

During 1999-2000, there were 22 new physicians who entered practice, and who at some point in time had received financial assistance from the Department of Health and Community Services through the following programs: Travelling Fellowship Program, Medical Student Rural Practice Incentive Program, Medical Specialist Resident Bursary Program, or Medical Student and Resident Practice Incentive Program.

With regard to surgical-dental services, four certified surgeons and one non-certified oral surgeon practiced in the Province. A total of 21 general practice dentists have hospital privileges.

5.4 Physician Compensation

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association, with involvement of the Newfoundland and Labrador Health Boards Association using traditional and formalized negotiation methods. The dispute resolution mechanism agreed to as a result of the current negotiations is mediation. The term of the current agreement is from April 1, 1999 to September 30, 2002.

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salaried, contract, and sessional block funding.

5.5 Payments to Hospitals

The Department of Health and Community Services is responsible for funding the Regional Health Care Boards and Health and Community Services Boards for ongoing operations and capital equipment purchases. Funding for insured services is provided to the Boards as an annual global budget and these annual funds are distributed in 12 monthly advance payments. As part of their accountability to government, Boards are required to meet the Department's Annual Reporting Requirements, which includes audited financial statements and other financial and statistical information. This process is consistent for all Regional Health Care Boards, Health and Community Services Boards and other grant-funded organizations within the Province.

Payments are made to Regional Health Care Boards and Community Health Services Boards in accordance with the *Department of Health and Community Services Act* and the *Hospitals Act*.

All Regional Health Care Boards and Health and Community Services Boards operate on a global budget basis whereby funding provided by the Province for approved programs is allocated by the Board. The global budgeting process devolves the budget allocation authority, responsibility, and accountability to all appointed Boards in the discharge of their mandates.

Throughout the fiscal year, the Health Boards can forward additional funding requests for changes in program areas or increased workload volume to the Department of Health and Community Services. These requests will be reviewed, and if approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for negotiated salary increases, additional approved positions or program changes are funded based on the implementation date of such increases and the cash flow requirement in a given fiscal year.

Boards are continually facing challenges in providing the required health care services and increased demands of the health system when costs are rising, staff workloads are increasing, patient expectations are higher, and new technology introduces new demands for time, resources, and funding. Boards are continuing to work with the Department of Health and Community Services to address these issues and provide effective, efficient and quality health care.

6.0 Recognition Given to Federal Transfers

Funding received under the Canadian Health and Social Services Transfer by the Province of Newfoundland and Labrador is noted in the Estimates, which represent the financial plan of the Province that is presented each year by the Government to the House of Assembly.

Reference is made to the *Canada Health Act* in the MCP Annual Report and other related publications.

7.0 Extended Health Care Services

Institutional long-term care, primarily for persons 65 years and older and persons with debilitating diseases, is provided in community health centres and nursing homes operated primarily by regional health boards that also deliver acute care services. Seven nursing homes continue to operate under independent boards. Residents pay a maximum of $2,800

per month based on a financial assessment. The balance of funding required to operate these facilities is provided by the Department of Health and Community Services.

The Department of Health and Community Services has strengthened community health programs to provide more appropriate preventive, support and home care services to help people avoid illness, to delay or reduce the need for institutional care, and to strengthen population health-focused programs and services throughout the Province.

Within their mandates, the Health and Community Services Boards have implemented a single-entry system to continuing care services. This has facilitated the coordination and delivery of a wide range of professional and support services to community health clients, including home care, assessment and placement, school and home support, palliative care, emergency response, rehabilitation and respite services.

The Department of Health and Community Services administers the Emergency Air and Road Ambulance programs through the Emergency Health Services Division. The Air Ambulance Program provides transportation and medical care to patients within the Province of Newfoundland and Labrador, and to hospitals outside the Province where warranted. Air Ambulance will also transport patients, medical staff, and equipment to and from the Province's isolated communities when required. The Road Ambulance Program provides medical care and transportation to residents accessible by road at a reasonable cost to the user. User fees are charged for both Road and Air Ambulance Program utilization.

Kidney donors and bone marrow/stem cell donors are eligible for financial assistance when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance Plan and the Medical Care Plan. Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the Province, may qualify for financial assistance under the Medical Transportation Program.

The Department of Health and Community Services provides two drug programs. The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who are in receipt of the Guaranteed Income Supplement from the federal government and who are registered with Old Age Security. Those eligible for this program are provided coverage for the ingredient portion of the cost of benefit prescription items. Any additional cost, such as dispensing fees, are the responsibility of the senior. Income support recipients are eligible for the income support drug program, which covers the full cost of benefit prescription items, including an established allowable markup amount and dispensing fee.

The Children's Dental Health Plan provides basic dental coverage up to and including 12 years of age. Basic services are also available for income support recipients 10 to 17 years of age. Relief of pain and infection services are available for adult recipients of social assistance.

Prince Edward Island

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan under the authority of the Minister of Health and Social Services is the vehicle for the delivery of hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act*, which insures services as defined under section 2 of the *Canada Health Act*.

Under Part I of the Act, it is the function of the Minister, and the Minister has the power to: ensure the development and maintenance throughout the Province of a balanced and integrated system of hospitals and schools of nursing and related health facilities; approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities; approve or disapprove all grants to hospitals for construction and maintenance; establish and operate, alone or in cooperation with one or more organizations, institutes for training of hospital and related personnel; conduct surveys and research programs and to obtain statistics for its purposes; approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations; subject to the approval of the Lieutenant Governor in Council, and to do all other acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

In addition to the duties and powers enumerated in Part I of the Act, it is the function of the Minister, and the Minister has power to: administer the plan of hospital care insurance established by this Act and the regulations; determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance, and to make retroactive adjustments with hospitals for under-payment or over-payment for insured services according to the cost as determined in accordance with the Act and the Regulations; receive and disburse all monies pertaining to the plan of hospital care insurance; approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance; enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons; to prescribe forms necessary or desirable to carry out the intent and purposes of the Act; appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon; appoint medical practitioners with the duty and power to examine and obtain information from the medical and other hospital records, including patients' charts with medical records and nurses' notes, reports, and accounts of patients who are receiving or have received insured services; appoint inspectors with the duty and power to inspect and examine books, accounts, and records of employers and collectors for the purpose of obtaining information related to the hospital and insurance plan; withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services; act as a central purchasing agent for the purchase of drugs, biologicals, or related preparations for all hospitals in the province, to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the province and to withhold or reduce payments under this Act to a hospital that does not comply with regulations respecting the purchasing of drugs, biologicals or related preparations; supervise

and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under this Act to a hospital that does not comply with the regulations respecting the use of such aids and procedures.

The Health Ministry, through the Department of Health and Social Services, has the responsibility for the overall efficiency and effectiveness of the provincial health system. Specifically, the Department is responsible for:

- setting overall directions and priorities;
- developing policies and strategies, legislation, provincial standards and measures;
- monitoring provincial health status;
- monitoring and making sure that the five regional health authorities comply with regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the five regional health authorities;
- improving the quality and management of a comprehensive province-wide health information system;
- ensuring access to high quality health services;
- addressing emerging health issues and examining new technology before implementation; and
- directly administering certain services and programs.

The five regional health authorities are responsible for service delivery. The Authorities operate hospitals, health centres, manors and mental health facilities, and hire physicians, nurses and other health-related workers. Their responsibilities include:

- assessing the health needs of the residents in their regions;
- providing for the input and advice of their residents;
- allocating and managing resources, set priorities, hire staff and make the best use of available resources;
- consulting with other organizations involved in the health field;
- developing policies, standards and measures;
- planning and coordinating with the Department and other authorities the delivery of the full range of health services;
- promoting health and wellness in their communities;
- making information available to their residents on choices about health and health services;
- ensuring reasonable access to health services; and
- monitoring, evaluating and reporting on performance to their residents and to the Ministry.

1.2 Reporting Relationship

An annual report is submitted by the Department of Health and Social Services to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on the operating principles of the Department, and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions and statistical highlights for the year.

Each of the five regional health authorities are required by statute to submit an annual report to the Minister of Health and Social Services. The Minister has the authority to request other information as deemed necessary on the operations of the Authorities and their delivery

of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The Provincial Auditor General conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department of Health and Social Services.

Each Regional Health Authority has the responsibility to engage its own public accounting firm to conduct annual financial statement audits. The audited financial statements are provided to the Ministry and the Department of the Provincial Treasury. The reports are presented at public meetings held annually within each region. Audited statements are also presented to the Legislative Assembly and included within the published Public Accounts of the Province of Prince Edward Island.

The Provincial Auditor General, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program-specific basis with respect to the operations of the Department of Health and Social Services, as well as each of the five Regional Health Authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in-patient and out-patient hospital services which are available at no charge to a person who is eligible. Insured hospital services include necessary nursing services; laboratory; radiological and other diagnostic procedures; accommodations and meals at a standard ward rate; formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital; operating room, case room and anaesthetic facilities; routine surgical supplies; and radiotherapy and physiotherapy services in hospital.

As of March 2000, there are seven acute care facilities that participate in the Province's insurance plan. In addition to acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, and seven insured chronic care beds. An additional facility, Prince Edward Home, has 50 insured chronic care beds. In addition, Prince Edward Island utilizes the equivalent of 50 acute care beds outside the province.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act*. Amendments were passed in 1996. Changes were made to include the physician resource planning process.

Insured physician services are provided by medical practitioners who are licensed by the College of Physicians and Surgeons. The number of practitioners that billed the Insurance Plan as of March 31, 2000 is 167. As of March 31, 2000 no physicians had opted out of the health care insurance plan.

A participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, collect fees outside of the plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include:

- most physicians' services in the office, at the hospital or in the patient's home;
- medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary;
- obstetrical services, including pre-natal and post-natal care, newborn care or any complications of pregnancy such as miscarriage or Caesarean section;
- certain oral surgery procedures performed by an oral surgeon when it is medically required that they be performed in a hospital;
- sterilization procedures, both female and male;
- treatment of fractures and dislocations; and
- certain insured specialist services, when properly referred by an attending physician.

No services were added in 1999-2000 to the list of insured physician services.

The process to add a physician service to the list of insured services is negotiated between the Department of Health and Social Services and the medical society of the province.

2.3 Insured Surgical - Dental Services

Dental services are not an insured service in the Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital as confirmed by the attending physician.

The addition of a surgical dental service is conducted through negotiations with the Dental Association and the Department of Health and Social Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include services that persons are eligible for under other provincial or federal legislation; mileage or travel, unless approved by the Department; advice or prescriptions by telephone, except anticoagulant therapy supervision; examinations required in connection with employment, insurance, education, etc.; group examinations, immunizations or inoculations, unless prior approval is received from the Department; preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility; testimony in court; surgery for cosmetic purposes unless medically required; dental services other than those procedures included as basic health services; dressings, drugs, vaccines, biologicals and related materials; eyeglasses and special appliances; physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments; reversal of sterilization procedures; *in vitro* fertilization; services performed by another person when the supervising physician is not present or not available; services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and any other services that the Department may, upon the recommendation of the Medical Advisory Committee, declare to be non-insured.

The process to de-insure services by the Health Care Insurance Plan is done so in collaboration with the Medical Society and Department of Health and Social Services.

De-insured in 1999-2000 from the list of insured services is the removal of impacted teeth. This service requires prior approval and remains covered when necessary.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act and Regulations*; section H-2 defines eligibility to the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone who is legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Armed Forces (CAF), Royal Canadian Mounted Police (RCMP), inmates of a federal penitentiary, and those who are eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents can become eligible in the following cases: members of the CAF, RCMP, and penitentiary prisoners on discharge, release, or release following the termination of rehabilitation leave where such is granted by CAF, the province where incarcerated or stationed at time of release of discharge, or the province where resident on the completion of rehabilitation leave as may be appropriate will provide initial coverage for the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

Foreign students, tourists, transients, or visitors to Prince Edward Island do not qualify as residents of the Province and are therefore not eligible for hospital and medical insurance benefits.

3.2 Registration Requirement

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks prior to renewal.

The number of residents registered for the health care Insurance plan in Prince Edward Island as of March 31, 2000 is 139,655.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There are 58 Kosovar Refugees registered for Medicare as of March 31, 2000.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the Province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences, must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province.

The term "temporarily absent" is defined as a period of absence from the province for up to 182 days in a 12-month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the province under the above circumstances must notify the Registration Department prior to leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside of Canada.

Insured residents may be temporarily out of the country for a 12-month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the registration department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes, coverage ends the day the person leaves.

For Island residents travelling outside of Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department.

The amount paid for insured emergency services outside of Canada for 1999-2000 was $75,500.

The payment rates are $576 per day for hospital stays. The standard inter-provincial out-patient rate is $110. The methodology used to derive these rates are as if the patient had the services provided on Prince Edward Island.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency out-of-province medical or hospital services. Prince Edward Island residents seeking such required services may apply for prior approval through a Prince Edward Island physician. Full coverage may be provided for (Prince Edward Island-insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department of Health and Social Services to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide for services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The seven acute care facilities in Prince Edward Island have a total of 474 (454 acute care + 20 rehabilitative) approved beds. There are also 16 acute care beds providing insured hospital services in a psychiatric facility. There are no admission data for these 16 beds. During the 1999-2000 fiscal year, the total number of inpatient admissions was 17,796. The number of in-patient days in Prince Edward Island hospital acute care beds totaled 148,473 (excluding newborns), with an average stay of 8.4 days.

In 1999-2000, there were 1,812 claims made by Prince Edward Island residents for out-of-province hospital services, and 14,428 visits to out-of-province out-patient departments. There are no data available on admissions, length of stay, or in-patient days for chronic care beds.

5.3 Access to Insured Physician and Dental Surgical Services

Physician services are accessible throughout the Province except for specialties where there are vacancies. Recruitment processes were undertaken for family physicians, one ear, nose and throat specialist, psychiatrists, a radiologist and one obstetrician. Several of these positions have been added to the complement (1999-2000) to provide better access to insured physician services. A recruitment strategy was announced that included incentives for recent graduates and new recruits, and an increase in medical seat resources for Prince Edward Island residents at medical schools outside the Province.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. The process incorporates a dispute resolution mechanism. Bargaining teams are appointed by both parties, physicians and government, to represent their interests in the process. The current three-year agreement will expire on March 31, 2001. The dispute resolution mechanism involves mediation and, if unsuccessful, binding arbitration.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*. One amendment made to the Act and Regulations in 1999-2000 includes the de-insurance of extractions of wisdom teeth. Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments.

5.5 Payments to Hospitals

Regional Health Authorities are responsible for the delivery of hospital services in the Province. The financial (budgetary) requirements are established annually through consultation with the Department of Health and Social Services and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to the Regional Health Authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The normal funding method includes the use of a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 Recognition Given to Federal Transfers

Federal contributions through the Canada Health and Social Transfer are identified as a specific line item within the published budgetary documents, which are presented annually in the Legislative Assembly of the Province.

7.0 Extended Health Care Services

Extended health care services are not an insured service, with the exception of the insured chronic care beds noted in section 2.1. Extended care services are provided through the 5 Regional Health Authorities of the Health and Social Services system. Nursing home services are available upon approval from regional admission and placement committees for placement into government manors and licensed private nursing homes. The standardized Services Assessment Screening Tool is used for determining service needs of residents for all admissions to nursing homes. There are 18 government and private nursing home facilities in the Province, with a total of 953 beds, including respite beds. The Province subsidizes 80 percent of residents in nursing homes as per the *Welfare Assistance Act Regulations*, Part 2. The remaining 20 percent of residents are self-paying. Nursing homes in Prince Edward Island provide Levels 4 and 5 care.

In addition to nursing home facilities, there are 29 licensed community care facilities in Prince Edward Island. As of March 31, 2000, the total number of licensed community care facility beds was 838. The 31 percent of residents who are subsidized require a financial assessment as per the *Welfare Assistance Act*, Part 1. The remaining 69 percent of residents are self-paying. Community Care facilities provide Levels 1 to 3 care.

Home Care and Support services, also uninsured, are another component of extended care. Support services include home care nursing, visiting homemakers, community support, adult protection, and occupational and physiotherapy supports. The Senior's Assessment Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client but are subject to a budget cap. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment. With demand for home care increasing, the Province is currently conducting a review of the program.

Nova Scotia

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Insurance Plan and the Medical Services Insurance Plan. The Department of Health administers the Hospital Insurance (HSI) Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, 35 (the Act), passed by the Legislature in 1958.

The Medical Services Insurance Plan (MSI) is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Maritime Medical Care Incorporated under the legislation previously mentioned.

Section 3 of the *Health Services and Insurance Act* states that, subject to this Act and the regulations, all residents of the Province are entitled to receive insured hospital services from hospitals upon uniform terms and conditions, and that all residents of the Province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend, or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Maritime Medical Care Incorporated (MMC), by virtue of the 1992 Memorandum of Agreement, is mandated to:

- determine the eligibility of providers participating in the Plan;
- plan and conduct information and education programs necessary to ensure that all persons and providers are informed of their entitlements and responsibilities under the Plan;
- make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable;
- develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfil its mandate.

1.2 Reporting Relationship

Maritime Medical Care is required to submit to the Province, no later than the 20th day of each month, monthly expenditure reports in a form, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, MMC is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. MMC is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc., that are charged to the MSI Plan. Reports prepared by Maritime Medical Care are forwarded directly to the Insured Programs Branch of the Department of Health for review and follow up.

1.3 Audit of Accounts

The Auditor General's office audits Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Maritime Medical Care. MMC also has an external audit conducted, which includes the administrative contract. No official audit is performed on the Medicare payments, however, this is being recommended by the Auditor General's office.

1.4 Designated Agency

Maritime Medical Care Incorporated administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement between the Department of Health and MMC. MMC receives written authorization from the Department of Health on the payees to which it may make payments. The rates of pay and specific amounts are dependent on the physician contract negotiated between the Medical Society of Nova Scotia and the Department of Health. MMC abides by the terms and conditions of the contract and its payment mechanism.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Thirty-four facilities deliver insured hospital services to in-patients and out-patients in Nova Scotia. Accreditation is not mandatory but most facilities are accredited at a facility or regional level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18,35, which was passed by the Legislature in 1958. Hospital Insurance Regulations were made pursuant to the *Health Services and Insurance Act*.

In-patient services include accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations, when administered in a hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; and blood or therapeutic blood fractions.

Out-patient services include laboratory and radiological examinations; diagnostic procedures involving the use of radio-pharmaceuticals; electroencephalographic examinations; use of occupational and physiotherapy facilities, where available; necessary nursing services; drugs, biologicals and related preparations; blood or therapeutic blood fractions; hospital services in connection with most minor medical and surgical procedures; day-patient diabetic care; services other than medical services provided by and within the Nova Scotia Hearing and Speech Clinic; ultrasonic diagnostic procedures; home parental nutrition; and haemodialysis and peritoneal dialysis.

2.2 Insured Physician Services

Legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35, and the Medical Services Insurance Regulations.

Under the *Health Services and Insurance Act* a general practitioner means a person who engages in the general practice of medicine or a physician who is not a specialist within the meaning of the clause, and a specialist who is a physician and is recognized as a specialist by the appropriate licensing body of the jurisdiction in which he or she practices. Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered

with the Provincial Dental Board and be recognized as dentists. In 1999-2000, 1,871 physicians and 55 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the Medical Services and Insurance Plan. In order to opt out a physician notifies MSI, relinquishing the billing number. Patients who pay the physician directly due to opting out, are reimbursed for these services by MSI. As of March 31, 2000, there were no non-participating physicians.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

No new large-scale services were added to the list of insured physician services in 1999-2000. However, on a quarterly ongoing basis new specific fee codes are approved that represent either enhancements or new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established present their case first to the Medical Society of Nova Scotia, which puts a suggested value on the proposed new fee.

The proposal is then passed to a Joint Fee and Tariff Committee for review and approval. The joint committee is comprised of equal members of the Medical Society and Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Maritime Medical Care is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the *Health Services and Insurance Act* a dentist is defined as a person lawfully entitled to practice dentistry in a place in which such practice is carried on by that person.

To be permitted to provide insured surgical-dental services under the Health Services and Insurance Plan, dentists must be registered members of the Association of Dentists and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the Medical Services and Insurance Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2000, there were no opt out dentists in Nova Scotia. Fifty-five dentists were paid through the MSI plan in 1999-2000 for providing insured surgical dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the Dental Surgical Program Fee Schedule. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth, oral and maximal facial surgery, etc. Additions to the list of surgical-dental services that are insured is accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include preferred accommodation at the patient's request; telephones; televisions; drugs and biologicals ordered after discharge from hospital; cosmetic surgery; reversal of sterilization procedures; surgery for sex reassignment; *in vitro* fertilization; procedures performed as part of clinical research trials; services such as gastric bypass for morbid obesity, breast reduction/ augmentation, and newborn circumcision, unless by exception because of medical necessity, and services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation; mileage, travelling or detention time; telephone advice or telephone renewal of prescriptions; examinations required by third parties; group immunizations or inoculations unless approved by the Department; preparation of certificates or reports; testimony in court; services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty; cosmetic surgery; acupuncture; reversal of sterilization; and *in vitro* fertilization.

All residents of the Province are entitled to those insured services covered under the *Health Services and Insurance Act*. If there is the ability for a patient to purchase enhanced goods and services, such as the foldable interocular lens or a fibreglass cast, patients are required to be fully informed about the cost and are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services articles.

The Department of Health carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed. Some physicians' offices in the Province have been giving individual patients the option of paying a block fee for uninsured services over the run of a year. However, all that have come to the Department of Health's attention have included the ability for the patient to refuse to pay a block fee and to pay for uninsured services on an as-you-go basis.

The de-insurance of insured services for physicians is accomplished through a negotiation process between the Medical Society of Nova Scotia and the Department of Health representatives who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary then it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental services and to hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined in the *Health Services and Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents. Persons moving to Nova Scotia from another country to live permanently are eligible on the date of their arrival in the Province provided they are Canadian citizens.

Members of the Royal Canadian Mounted Police, members of the Canadian Armed Forces, federal inmates and members of North Atlantic Treaty Organization are ineligible for MSI coverage. When their ineligibility status changes, they become eligible on the first day of the third month following the month in which they became eligible.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents will apply to MSI for registration. These forms must be returned to MSI with the name and mailing address of a witness (a Nova Scotia resident who can confirm that all the information on the application is correct). The application must also be accompanied by a Canadian birth certificate, a Canadian immigration certificate or other verification that applicant is entitled to remain in Canada. If the application is complete and the eligibility criteria have been met, MSI will then issue a health card. The health card must be shown for each insured service received. Renewal notices are sent out from MSI to the permanent address of the resident of Nova Scotia. Upon return of a signed renewal notice MSI will issue a new health card. Each application and health card number is unique and allocated on an individual basis.

As of March 31, 2000, the number of residents registered with MSI was 946,840.

There is no legislation in Nova Scotia forcing residents of the Province to apply for MSI. There are residents who, therefore, are not members of the health insurance plan. Failure to provide a renewal notice effectively cancels a resident's right to service, until they renew.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia once they meet the specific eligibility criteria for their situation. Eligibility criteria are as follows:

Immigrants: Persons in possession of landed immigrant documents and who are referred to as permanent residents are eligible on the date of their arrival in Nova Scotia. Persons in possession of any other documents, who have applied in Canada for permanent residence status, are eligible on the date of application for permanent resident status, provided they are in possession of a letter from the Immigration Department.

After residing in Nova Scotia for six months, persons with employment visas are eligible for coverage retroactive to the day of their arrival provided they have not been absent from Nova Scotia for more than 31 consecutive days and they intend to be employed in Nova Scotia for a further six months.

Work Permits: Persons moving to Nova Scotia from another country who are in possession of an employment authorization are eligible to apply for MSI on the first day of the seventh month following the date of arrival as a worker, provided they have not been absent from Nova Scotia for 31 consecutive days, except in the course of employment.

Students: Persons moving to Nova Scotia from another country who are in possession of a student authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days.

Sebaticans: Persons on employment sabbatical are treated in the same manner as all other Nova Scotia residents. Sebaticans must return to Nova Scotia within 12 months. All absences of more than the usual six months must receive prior approval before MSI coverage will be extended.

Refugees: Refugees are not insured if they are not legally entitled to remain in Canada. This includes persons awaiting a decision from Employment and Immigration Canada as to whether they will be permitted to remain in Canada. Refugees with work permits are governed by the eligibility provisions for persons with work permits.

As of March 31, 2000 there were 336 individuals residing in Nova Scotia and covered under the above conditions.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for Medical Services Insurance (MSI) on the first day of the third month following the month of their arrival as permanent residents.

4.2 Coverage During Temporary Absences In Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services. As well, several Orders-in-Council, including MSI Regulation Order-in-Council 72-783, ensure that portability will be provided.

Generally the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students temporarily absent from Nova Scotia and in full-time attendance at an educational institute remain eligible for MSI on a yearly basis, provided they supply a letter each year stating they are registered as full-time students.

Workers on work permits who leave Nova Scotia to seek employment elsewhere will remain covered by MSI for up to 12 months, provided they do not establish residence in another province, territory, or country.

Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement as well as the Medical Reciprocal Billing Agreement. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the plan in 1999-2000 for in-patient and out-patient hospital services received in other provinces and territories were: $9,704,639 for out-of-province in-patient services, and $3,504,388 for out-of-province out-patient services. In all reciprocal billing situations Nova Scotia pays the host province rates for insured services.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside of Canada. Provided a Nova Scotia resident has not been out of the country for more than six months, out-of-country services will be paid as a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. In order to be covered, procedures of a non-emergency basis must have prior approval before they will be covered by the Nova Scotia Medical Services and Insurance plan.

However, students temporarily absent from Nova Scotia and in full-time attendance at an educational institution remain eligible for MSI, provided they demonstrate registered, full-time student status.

Workers who leave Nova Scotia to seek employment elsewhere remain covered by MSI for up to 12 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent for 1999-2000 for insured in-patient and out-patient emergency services provided outside of Canada was $1,053,577. (Daily rate = CDN $525 per day).

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services in another province or out of the country. Application for prior approval is made to the Medical Director of the Medical Services Insurance plan by a physician in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the province or whether the service can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's physician. The patient is then covered under the reciprocal billing agreement for elective services in another province or territory of the country. If approval is given for a resident to obtain service out-of-country the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions.

There are no user charges or extra charges under either plan.

No barriers to access exist in Nova Scotia.

5.2 Access to Insured Hospital Services

The government of Nova Scotia continues to place emphasis on the provision of sustainable, quality health care services to its citizens.

As of March 31, 2000, 3,125 acute care hospital beds were available in Nova Scotia.

The following provides a breakdown of key health professions that support insured hospital services in Nova Scotia (Table 1).

Table 1

Health Profession	Total # Employed	Status of Work	Percent	Comments
Physicians (Family Medicine-956; Specialists-915)	1,871			Nova Scotia has sufficient GPs, specialists and dentists to provide insured services to the residents of this province. The latest CIHI report ranks Nova Scotia as the second highest in Canada for physician-to-population ratio.
Dentists	394			
Registered Nurses	8,840	Regular F/T Regular P/T Casual F/T Casual P/T	54 24 6 17	Overall increase over previous year
Licensed Practical Nurses	2,888	Regular F/T Regular P/T Collectively Casual F/T Casual P/T	51 32 18	
Radiation technology	392			28 % attrition rate over the next 8 years
Radiation therapy	26	Collectively		9 % attrition rate
Nuclear medicine technology	58	Regular F/T Regular P/T Casual F/T Casual P/T	70 20 5 5	12 % attrition rate
Ultrasonography	76			11 % attrition rate
Diagnostic cytology	33			11 % attrition rate
Health records science	169			11 % attrition rate
Medical laboratory technology	1,000			29 % attrition rate
Respiratory therapy	186			17 % attrition rate
Overall participation rate	Overall in Nova Scotia, there is acceptable participation of health professionals in the provision of insured services			

In Nova Scotia in 1999-2000, Telehealth was used to provide the following services (Table 2):

Table 2

Type of Telehealth Event	Number of "Events"
Tele-radiology Cases	15,991
Education Sessions	1,031
Clinical Consultations	410
Administrative Meetings	332
Clinical Case Conferences	32

The Department of Health is currently reviewing its Decision Support System to ascertain how to get more comprehensive provincial data on wait times.

5.3 Access to Insured Physician and Dental-Surgical Services

Nova Scotia ranks second highest for physician-to-population ratio in Canada. As of December 31, 1999, there were 1,871 physicians and 55 dentists providing insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

Nova Scotia has had a seven percent increase in physician numbers since 1995. Incentives have been created, such as assistance with moving allowance, etc. An ongoing recruitment program has been successful in locating physicians to under-serviced areas.

The Province has increased general practice medical training by the addition of 12 positions. The Province also conducts ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the Province.

5.4 Physician Compensation

The *Health Services and Insurance Act* RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between the Medical Society of Nova Scotia and the Nova Scotia Department of Health. The Medical Society of Nova Scotia is recognized as the sole bargaining agent in support of physicians in the Province. When negotiations take place representatives from the Medical Society and the Department of Health negotiate the total funding and other terms and conditions and enhancements that the Medical Society may bring to the table in light of the fiscal restraints on the Province. Each negotiated agreement attains a provision for binding arbitration, should there be an impasse in a dispute resolution. The current master agreement negotiated April 1, 1987 and which expires March 31, 2001, contains an alternate dispute resolution mechanism.

The agreement lays out what the master unit value will be for physician services and addresses issues of stand-by or call-back compensation, members benefit fund, Canadian Medical Protective Association funding and royalty stabilization funding. As well, there is provision for a Harmonized Sales Tax rebate. Fee-for-service is still the most prevalent method of payment for physician services.

Other payment methods include hourly rate funding, hourly funding, and sessional funding.

During 1999-2000, payments for fee-for-service in Nova Scotia totaled $216,837,726. The Department paid an additional $4,441,830 for insured physician services provided to Nova Scotia residents outside the Province, but within Canada.

Payment rates for dental services in the province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a similar process to physician negotiation. Dentists are paid on a fee-for-service basis. The current agreement is due to expire March 31, 2001.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the four Regional Health Boards and the four large tertiary care hospital facilities. Approved provincial estimates form the basis on which payments are made to the Regional Health Boards and the large tertiary care hospitals.

In 1999-2000, there were a total of 3,125 (3.3 per 1,000 population) hospital beds in Nova Scotia. Department of Health direct expenditures for insured hospital services' operating cost were $812.8 million. Payments to out-of-province hospitals for insured services to Nova Scotia residents were $9.7 million. Total separations from all hospitals were 208,580.

6.0 Recognition Given to Federal Transfers

In Nova Scotia the *Health Services and Insurance Act* RS Chapter 197 acknowledges the federal contribution in respect of the cost of insured hospital services and insured health services provided to residents of the province. The residents of Nova Scotia are aware,

through press releases and media coverage of ongoing negotiations between the provinces and the federal government that federal Canada Health and Social Transfer (CHST) funding partially assists in the provision of insured medical services in the Province.

7.0 Extended Health Care Services

These following services are not considered medically necessary services and, as such, are not insured services under the *Canada Health Act*.

Nursing Homes

Nursing homes in Nova Scotia provide care primarily to seniors at Level I and Level II care. Level I care deals with residents in homes requiring personal care and assistance with activities of daily living. Level II care involves Level I care plus specific nursing care. This level of care is increasing dramatically as the population ages. The aging-in-place phenomenon means those seniors who were Level I are rapidly moving into Level II.

Adult Residential Care Services

Adult Residential Care Services In Nova Scotia come under the jurisdiction of the Department of Community Services. There are, however, Residential Care Facilities that provide Level 1 care as described above.

Home Care Services

Home Care Nova Scotia was introduced in Nova Scotia in 1995. This program assists seniors to remain in their own homes longer thus delaying admission to a long term care facility. Primarily, Home Care Nova Scotia provides personal care in clients' homes along with nursing care, if required. The two major components of the program are chronic and acute patient care. The chronic component makes up approximately 80 percent of home care clients with the remaining 15 to 20 percent being acute home care, which allows for early discharge from hospital. Home Care Nova Scotia also provides a home oxygen program. This program is still developing, and other components will be added in the future, such as occupational therapy, physiotherapy, social work, palliative care, pediatrics, and others as deemed required.

Nova Scotia is embarking on the implementation of a single entry access model, which will be demonstrated October 1, 2000, with full implementation on April 1, 2001.

New Brunswick

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick the Health Care Insurance Plan is known as the Medical Services Plan and the public authority responsible for operating and administering the Plan is the Minister of Health and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1,1971.

The Act and its Regulations specify the eligibility criteria, the rights of the beneficiary, and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured, and the uninsured services. The legislation also stipulates the types of agreement the provincial authority may enter into with provinces/territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner, how the amounts to be paid for entitled services will be determined, how assessment of accounts for entitled services may be made, and the confidentiality and privacy issues as it relates to the administration of the Act.

The Minister of Health and Wellness is responsible for establishing a medical services plan that identifies the beneficiaries of the plan, which services are and are not covered, and the amounts to be paid for entitled services. Under the plan, the Minister assesses and audits physician billings through inspectors appointed by him or her and through a professional review committee. The Minister also has the authority to recover the cost of entitled services against a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Public Health and Medical Services Division of the Department of Health and Wellness is mandated with the administration of the Medical Services Plan. The Minister reports either through the Department's Annual Report or through the regular legislative processes.

1.3 Audit of Accounts

There are three groups with the mandate to audit in the area of the Medical Services Plan.

1. **The Auditor General**

   - in accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which include the financial records of the Department of Health and Wellness. For 1999-2000, all transactions of the Department were exposed to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report on identified errors and control weaknesses.

2. **The Office of the Comptroller**

   - the Comptroller is the chief internal auditor for the Province of New Brunswick and is charged with carrying out internal audit activity in accordance with responsibilities and authority under the *Financial Administration Act*. The objective of an internal audit is to fulfil the Comptroller's mandate as it relates to Appropriations Audit, Information

Systems Audit, Statutory Audits and Value-for-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited;

- the most recent audit was the "Medicare Internal Control Review" which covered the fiscal year 1998-1999. The objective of the review was to ensure that adequate control exists over the disbursement of Medicare payments. They concluded "that overall, existing system, audit and assessment functions and controls currently provide a reasonable level of assurance that payments are accurate and legitimate". Recommendations were made to improve the efficiency and coverage of preventative measures taken and in the area of management of Medicare Audit recoveries.

3. **Department of Health and Wellness Internal Audit**

- the Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives;
- reviews of program areas are usually done on a cyclical basis with a major program covered once every three to four years. No reviews were performed on these programs for 1999-2000.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes:

- *Hospital Services Act*, 1973, and its Regulation 86-74, section 9 of the Regulation identifies entitled services.
- *Hospital Act*, assented to May 20, 1992 and its Regulation 92-84

In 1999-2000, section 1 of the *Hospital Services Act* and Regulation 84-167 under the *Hospital Services Act* were amended to reflect changes to government departments. The term "Health and Wellness" has replaced all previous references to "Health and Community Services".

There are eight Region Hospital Corporations (RHCs), established by legislation. Each RHC includes a regional facility and a number of smaller facilities, all of which provide insured services to in-patients and out-patients. Each RHC has other health facilities and/or health centres, without designated beds, which provide a range of services to entitled persons.

Proposed changes to the provision of hospital services by the Region Hospital Corporation, are reviewed by the Hospital Services Branch of the New Brunswick Department of Health and Wellness and, if acceptable, approved by the Minister. While there is no standard process for public consultation, RHC Boards include public representation.

No hospital operation, beyond that specified in the *Hospital Act*, is permitted. Hospital accreditation by the Canadian Association on Health Facilities Accreditation is encouraged but not required.

2.2 Insured Physician Services

The enabling legislation providing for insured physician services in New Brunswick is the *Medical Services Payment Act* (MSPA).

The MSPA was assented to on December 6, 1968. Regulation 84-29 was filed on February 13,1984, Regulation 93-143 was filed on July 26,1993, Regulation 96-113 was filed on November 29, 1996 and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13,1999.

There were two amendments made during 1999-2000 with regard to insured physician services:

1) Section 8 of the *Medical Services Payment Act* was amended by adding:

   8(1.1) Notwithstanding paragraph (1)(b), a person employed in the administration of this Act shall not release to a medical practitioner the name of any person who has complained to the provincial authority about the billing practices or provision of entitled services by the medical practitioner or the nature of the complaint, except as required by law or where the matter complained of is referred to the Professional Review Committee under section 5.5.

2) Sections 14.5 (1) (2), 2,3,4 were amended on April 13,1999. These changes were required to reflect the increases in the threshold levels for individual caps.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions a physician must meet to participate in the New Brunswick Medical Services Plan are:

- maintain current registration/licence with the New Brunswick College of Physicians and Surgeons;
- be a member of the New Brunswick Medical Society;
- hold privileges in a Region Hospital Corporation; and
- sign the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's *Medical Services Payment Act* as of March 31, 2000 was 1,350.

Physicians in New Brunswick have the option to opt out totally or for selected services. Opted out practitioners are not paid directly by Medicare for the services they render. They must bill their patients directly in all cases. The patients are not entitled to a reimbursement from Medicare.

The opting out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. If an opted-in practitioner wishes to opt out for a service, then he or she must first obtain the patient's agreement to be treated on an opted out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The practitioner must advise the patient in advance and:

a) if the charges do not exceed the Medicare tariff, the practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare;

b) if the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the service that:

   - they are opting out and charging fees above the tariff;
   - in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and

- the patient is entitled to seek services from another practitioner on an opted-in basis.

The physician must obtain a signed waiver from the patient on the specified form and forward it to Medicare.

At present there are no physicians rendering health care services who have elected to opt out of the Plan.

The range of entitled services under Medicare New Brunswick includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed either by a physician or by a dental surgeon in a hospital facility.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests would be considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on the conformity to "medically necessary" and whether the service is considered as generally acceptable practice (not experimental) within New Brunswick/ Canada. Considerations under the term "medically necessary" include services required for the purpose of maintaining health, preventing disease and /or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

The range of surgical-dental services under New Brunswick Medicare are payable only to oral and maxillofacial surgeons. A general dental practitioner may be paid to assist another dentist for services that are medically required to be performed in a hospital and are included in Schedule 4 of Regulation 84-20 (filed June 23, 1998) under the *Medical Services Payment Act*. Schedule 4 identifies the insured surgical-dental services that can be provided by a qualified medical practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital.

The conditions a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the NB Medicare Dental registration form).

The number of dental practitioners registered with New Brunswick Medicare is 57, although many do not provide insured services.

Dentists have the same opting out provision as previously explained for physicians and must follow the same guidelines. The Department of Health and Wellness has no data for the number of non-enrolled dental practitioners in New Brunswick.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured Hospital Services

Uninsured services include patent medicines; take-home drugs; third-party requests for diagnostic services; visits for the administration of drugs, vaccines, sera or biological products; televisions, telephones; preferred accommodation at the patient's request; hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*. Services are not insured if provided to those entitled under other statutes.

There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (i.e., enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.) provided in conjunction with an

insured health service do not compromise reasonable access to insured services.

Uninsured Physician and Surgical-Dental Services

The services listed in Schedule 2 of the Regulation (84-20) under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

(a) elective plastic surgery or other services for cosmetic purposes;
  (a.01) correction of inverted nipple;
  (a.02) breast augmentation;
  (a.03) otoplasty for persons over the age of 18;
  (a.04) removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;
  (a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;
  (a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;
(b) medicines, drugs, materials, surgical supplies or prosthetic devices;
(c) vaccines, sera, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;
(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
(f) dental services provided by a medical practitioner;
  (f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
  (f.2) services that are provided in conjunction with or in relation to the services referred to in paragraph (f.1);
(g) testimony in a court or before any other tribunal;
(h) immunization, examinations or certificates for purposes of travel, employment, emigration, insurance, or at the request of any third party;
(i) services provided by medical practitioners to members of their immediate family;
(j) psychoanalysis;
(k) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;
(l) laboratory procedures not included as part of an examination or consultation fee;
(m) refractions;
  (m.1) services provided within the Province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;
(n) the fitting and supplying of eyeglasses or contact lenses;
(o) transsexual surgery;
  (o.1) radiology services provided in the Province by a private radiology clinic;
(p) acupuncture;
(q) complete medical examinations when performed for purposes of a periodic check-up and not for medically necessary purposes;
(r) circumcision of the newborn;
(s) reversal of vasectomies;
(t) second and subsequent injections for impotence;
(u) reversal of tubal ligations;
(v) intrauterine insemination;
(w) gastric stapling or gastric by-pass; and
(x) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

All dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical services plans across the country and the previous utilization of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the Government may not make any change to the Regulation until the advice and recommendation of the New Brunswick Medical Society is received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to the receipt of their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation is used.

No medical or surgical-dental services were removed from the insured service list in 1999-2000.

3.0 Universality

3.1 Eligibility

The *Medical Services Payment Act* and its Regulation 84–20, sections 3and 4 define eligibility to the health care insurance plan.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian Immigration permit. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient or visitor to the Province.

All persons entering or returning to New Brunswick have a waiting period prior to becoming eligible for coverage. Coverage commences the first day of the third month following the month of arrival. An exception was made to grant first-day coverage for bona fide missionaries who were previously registered residents of New Brunswick at time of their departure from the country.

Residents who are ineligible:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police;
- federal inmates; and
- persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province.

Non-Canadians who are issued certain types of Canadian Immigration permits. An example would be a Student Authorization.

Provisions to become eligible:

- non-Canadians who are issued an Immigration permit that would not normally entitle them to coverage are eligible if legally married to an eligible New Brunswick resident.

Provisions when status changes:

- upon discharge or release from the Canadian Armed Forces, the RCMP or a Federal Penitentiary, provided they are residing in New Brunswick at the time of discharge/release persons are eligible for

coverage on their date of release. They must complete an application, provide the official date of release/discharge and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependants under the age of 19, on a registration form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependants are registered and a Medicare card with an expiry date is then issued to the beneficiary and for each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary 2-3 months prior to the expiry date of the Medicare card(s). A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and to sign and return the form to Medicare. Upon receipt of the completed form the file is updated and new card(s) issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are actually registered.

All family members, i.e. the beneficiary, spouse and dependants under the age of 19 are required to register as a family unit. Residents who are co-habitating, although not legally married, are eligible to register as a family unit if they so request.

The number of residents registered as of March 31, 2000 was 738,745.

Residents may opt out if they choose. They are asked to provide a written confirmation of their intention. This information is then added to their file and benefits are terminated. Only three residents have opted out.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided they are legally married to an eligible New Brunswick resident and remain in possession of a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. In 1999-2000, approximately 50 individuals were covered under these conditions.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences In Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, Regulation 84 – 20, sections 3 (4) and 3 (5)

Students in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another province, are granted coverage for a 12 month period that is renewable provided they:

- ❑ contact Medicare once in every 12 month period to retain their eligibility;

- do not establish residence outside New Brunswick; and,
- do not receive health coverage in another province.

Residents who are temporarily employed in another province or territory are granted coverage up to 12 months provided they:

- do not establish residence outside the Province;
- do not receive coverage in another province or territory; and
- intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the province or territory where they are employed and should be entitled to coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all provinces and territories for the reciprocal billing of insured hospital services. As well, New Brunswick has reciprocal agreements with all provinces except Quebec for the provision of insured physicians' services. Services provided by Quebec physicians to New Brunswick patients are paid at Quebec rates, if the service is insured in New Brunswick. The majority of such claims are received directly from the Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient according to New Brunswick regulations.

During 1999-2000, New Brunswick paid to other provinces/territories:

Hospital In-patient	Hospital Out-patient	Medical
$22,473,974.19	$4,235,428.57	$7,489,796.00

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act*, Regulation 84 – 20, sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12-month period that is renewable provided they:

- provide proof of enrolment;
- contact Medicare once every 12 month period to retain their eligibility;
- do not establish permanent residence outside New Brunswick; and
- do not receive health coverage elsewhere.

Temporary Workers: Residents temporarily employed outside the country are granted coverage up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12 month period, provided they do not establish residence outside the country. Any absence over 182 days, whether it be for work purposes or vacation, would require "Director's Approval". This approval can only be up to 12 months in duration and only be granted once every three years. Families will continue to be covered, provided they reside in New Brunswick.

Exception to Temporary Workers: Mobile Workers are residents whose employment requires them to travel frequently outside the Province. Certain guidelines must be met to receive Mobile Worker designation. They are:

- their applications must be submitted in writing;
- documentation is required as proof of Mobile Worker status, i.e. letter from employer, photocopy of Immigration permits;

- permanent residence must remain in New Brunswick; and
- the person must return to New Brunswick during their off-time.

Mobile Worker designation is assigned for a maximum of three years, after which the resident must reapply and resubmit documentation to confirm status.

For teachers employed in Louisiana there is a special provision for a maximum two-year coverage.

New Brunswick Medicare covers out-of-country medical and hospital services for emergency out-patients and resulting in-patient services only. Medicare pays New Brunswick rates for physician services associated with the emergency interventions. The associated facility rates, paid in Canadian funds are: in-patient $100.00 per day, out-patient $50.00 per visit.

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost.

1999 - 2000		
Hospital In-patient	**Hospital Out-patient**	**Medical Services**
$487,760	$105,782	$356,128

4.4 Prior Approval Requirement

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country if they fulfill certain requirements, which are:

- the required service(s) must be unavailable in Canada;
- it must be rendered in a hospital listed in the AHA Guide (Guide to United States Hospitals, Health Care Systems, Networks, Alliances, Health Organizations, Agencies and Providers);
- the service(s) must be rendered by a medical doctor; and
- the service(s) must be an accepted method of treatment recognized by the medical community and scientifically proven. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. The physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation.

The following are considered exemptions under the out-of-country coverage policy:

- haemodialysis. Patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the interprovincial rate;
- allergy testing for environment sensitivity. All tests sent outside the country will be paid at a maximum of $50.00 per day, an amount equivalent to an out-patient visit.

Prior approval is also required for referral of patients to psychiatric hospitals and centres outside the Province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received from the referring physician(s).

5.0 Accessibility

5.1 Access to Insured Health Services

Since there are no health care user fees in New Brunswick, all residents have equal access to insured health services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds by the Region Hospital Corporation. The number of approved beds, as of March 31, 2000, is shown in Table 1 .

Table 1: Approved Beds as of September 2000

Bed Type		Number	Percent of Total Beds
Non-Tertiary	Acute	2,878	69%
	Restorative	397	10%
	Addictions	174	4%
	Corrections Canada	2	0%
	Veterans Affairs Canada	187	4%
	Sub-Total	3,638	88%
Tertiary	Oncology	80	2%
	Cardiac Surgery	26	1%
	Neurosurgery	46	1%
	Tertiary Psychiatry	346	8%
	Tertiary Rehabilitation	20	0%
	Sub-Total	518	12%
Provincial Total		4,156	100%

As of March 31, 2000, a total of 3979.34 full-time equivalent registered nurses were required to provide services in all hospital facilities in the Province for a typical 24 hour period of operation.

All facilities that provide CHA insured services have the appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated level of care. As of March 31, 2000 there were nine computed tomography (CT) scanners operating in the Province, one in each of the eight Region Hospital Corporations, with an additional unit in the Atlantic Health Sciences Corporation (Region #2). The Province also has two mobile magnetic resonance imaging (MRI) units in operation.

In 1999-2000, the following initiatives served to improve access to insured hospital services in New Brunswick.

- Telephsychiatry was piloted in Region 2 Hospital Corporation to provide improved access to psychiatric consultation for patients in rural areas;
- Telenephrology was introduced in Region 1 Beauséjour Hospital Corporation;
- the Provincial Renal Services Coordinating Committee was established;
- introduction of renal dialysis in Region 3 Hospital Corporation;
- introduction of a mobile (MRI) unit between Region 3 Hospital Corporation and Region 4 Corporation;
- a system planning committee was established to provide advice to the Minister regard to health system planning and to ensure that decisions undertaken by government are evidence-based and reflective of both regional perspectives and provincial visions;
- financial support to Region 1 Hospital Corporation Beauséjour for radiation oncology services.

5.3 Access to Insured Physician and Dental-Surgical Services

A total of 629 family practitioners, 721 specialists and 12 dentists provided insured services in New Brunswick during fiscal 1999-2000.

The Province's physician resource plan (July 1992) establishes the number of family practitioners and specialists by health region required by 2003-2004. A physician recruitment and retention strategy was launched with an annual commitment of $6.8 million.

In fiscal 1999-2000, the Department introduced a comprehensive multi-year recruitment and retention strategy aimed at attracting newly licensed family practitioners and specialists that included, in part; hiring a physician recruitment officer; expanding practice opportunities for foreign-trained physicians, the summer employment program for medical students and the supernumerary residency training sponsorship; developing a provincial physician "locum pool" to cover vacation/sick leave; implementing location grants for physicians willing to practice in hard-to-recruit areas; purchasing 10 additional seats at Memorial University Medical School for fall 2000; increasing government involvement in post-graduate training of family physicians and working toward increased physician remuneration to achieve parity with other Atlantic jurisdictions.

As this strategy was implemented in late 1999-2000, initial reportable results will be available in fiscal 2000-2001.

5.4 Physician Compensation

The current agreement between the Department of Health and Wellness and the New Brunswick Medical Society is a Memorandum of Understanding for 1999-2000 that expired in March 2000. Discussions are ongoing for the year 2000-2001. A dispute resolution mechanism is provided for in Legislation, which includes mediation and binding arbitration.

There is no formal negotiation process for dental practitioners.

Payments to physicians and dentists are governed under the *Medical Services Payment Act* (Regulations 84-20, 93-143, 96-113).

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary, and sessional or alternate payment mechanisms that could also include a blended system.

5.5 Payments to Hospitals

The primary acts of legislation governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Services Act*, which governs the financing of hospitals.

Other than amendments to change the name of the Department to "Health and Wellness", there were no changes during fiscal year 1999-2000 affecting the hospital payment process.

The Department utilizes two components to distribute available funding to the Region Hospital Corporations:

1) The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:

   - ❑ tertiary services (cardiac, dialysis, oncology);
   - ❑ psychiatric services (psychiatric units and facilities);
   - ❑ dedicated programs (e.g., addiction services);

- community based services (Extra-Mural Program; health service centres); and
- general patient care.

Added to this are the non-patient care support services (e.g., general administration, laundry, food services, energy, etc.).

The CSL approach establishes base budgets for the eight RHCs for the above-noted programs and services, with measures for population and service volumes. The base budgets are then adjusted annually for inflation and other factors such as centrally negotiated labour rates.

2) A gradual phasing in of a population-based funding distribution formula starting with the 1999-2000 and 2000-2001 fiscal years. This methodology attempts to predict the appropriate distribution of available funding for the Region Hospital Corporations based on demographic population characteristics and current market share of patient volumes with cases measured by "Resource Intensity Weights." Currently, this methodology is more suitable to in-patient volumes because of a lack of case grouping and weighting methodologies for out-patient volumes, especially tertiary out-patient services, (e.g., oncology and haemo-dialysis).

The current budget process can extend over more than one fiscal year and includes several steps. By January of each year, the RHCs provide the Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current year. These, along with the audited financial statements from the prior two years, are used to evaluate the expected funding level for each RHC.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either a recurring or non-recurring basis. The "year-end settlement process" reconciles the total annual approved budget for each RHC to its audited financial statements along with reconciling budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

The Province routinely recognizes the Federal role regarding its contributions under the Canada Health and Social Transfer (CHST) through public documentation presented through the legislative and/or administrative processes. New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

The New Brunswick Long Term Care (LTC) program, a non-insured service, was transferred under the Department of Family and Community Services (DFCS) on April 1, 2000. Nursing home care is also provided through the Nursing Home Services Program of DFCS. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the Province.

Residential and Extended Care Services

Table 2 identifies residential and extended-care services available in New Brunswick as of March 31, 2000. Nursing homes are private not-for-profit organizations, except for one that is owned by the Province. In order to be admitted to a nursing home, clients have to go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities are for the most part private for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open or close residences. Clients are admitted after going through the same evaluation process used for nursing homes.

Public Housing Units are available for low-income elderly persons. Admission criteria are based on the age and financial situation of clients. The Victorian Order of Nurses (VON) offers support services to some units.

Table 2: Availability of Residential and Extended Care

Service	Number of Units or Beds
Nursing Home Beds	4,140
Adult Residential Facilities* (beds)	5,341
Public Housing (Units)	2,088
Provincial Total	11,569

* Includes Special Care Homes and Community Residences.

Ambulatory Health Care

In New Brunswick, "ambulatory health care" includes services provided in hospital emergency rooms, day/night care in hospitals, and in clinics as may be available in hospital facilities and health centres. This service is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also called the "hospital at home" program, is an active treatment program of acute, palliative and long term health care provided in community environments, (e.g., an individual's home, nursing home, or public school). The eight Region Hospital Corporations have been responsible for the delivery of the Extra-Mural Program since 1996. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists, and speech language pathologists. This service is considered an insured service under the provincial Hospital Services Plan.

Quebec

Statement from Quebec

In this report, the information pertaining to Quebec is presented in the same way as in the previous annual reports prepared by Health Canada to meet the legislative requirements that have existed since the adoption of the *Canada Health Act*.

The government of Quebec, owing to its constitutional jurisdiction in the area of health, is accountable to the National Assembly and to Quebecers for its management of health services. In that connection, it regularly makes public various documents and reports on, among other things, the health of the population, patient satisfaction and the organization of health and social services in its territory. Most of these documents can be accessed on the Internet site of Quebec's health and social services department, the Ministère de la Santé et des Services sociaux.

Federal Response to Quebec

The Minister of Health is accountable to Parliament and to Canadians regarding the monitoring of compliance by provinces and territories with the *Canada Health Act*. Section 23 of the *Canada Health Act* requires that an annual report to Parliament be prepared by no later than December 31 of each year on the Act's administration and operation for the previous fiscal year. The annual report is to include "all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act". The provincial and territorial governments are the source of the information required for fulfilling this statutory reporting obligation.

In 1999, the Auditor General of Canada recommended that "in its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons". In responding to the Auditor General's recommendation that *Canada Health Act* monitoring and compliance assessment activities be improved, Health Canada has this year standardized the format of the *Canada Health Act* Annual Report and expanded on the content to enable a better understanding of whether the *Canada Health Act* is being complied with by provinces and territories. In this regard, Health Canada has reviewed the information contained on the Quebec Internet site and has concluded that there is insufficient information for citizens to determine, for example, whether patients are being charged for insured services at private clinics, or whether insured services are portable in accordance with the provisions of the Act.

All provinces and territories were advised of the change in format and content requirements, and were offered technical advice and assistance in the completion of their submissions through numerous teleconferences and a multilateral meeting. All provinces and territories, Quebec excepted, agreed to fulfill the revised format and content required. The federal government is concerned that Quebec is not providing sufficient information to effectively assess compliance with the *Canada Health Act* and satisfy the recommendations of the Auditor General. In the health accord agreed to on September 11, 2000, First Ministers committed to strengthening and renewing publicly funded health care services through partnership and collaboration. The federal government will continue to work with Quebec to ensure that information is made available to demonstrate compliance with the *Canada Health Act*.

Quebec

Public Administration

Hospital Insurance and Medical Care Plans

The hospital insurance plan, the *régime d'assurance-hospitalisation du Québec*, is administered by the Ministry of Health and Social Services, the *ministère de la Santé et des Services sociaux*.

The health insurance plan, the *régime d'assurance maladie du Québec*, is administered by the *Régie de l'assurance maladie du Québec*, a public authority appointed by the provincial government and responsible to the Minister of Health and Social Services. Both plans are operated on a non-profit basis, and all accounts and transactions are audited by the Auditor General of the province.

Comprehensiveness

Hospital Insurance Plan

The network of establishments under the Ministry of Health and Social Services includes hospital centres, certain residential and extended-care facilities (formerly extended-care hospital centres[1]) and local community services centres.

The treatment of physical and mental illness is provided by the hospital centres, and by some of the residential and extended-care facilities.

Insured in-patient services are provided in the hospital centres, whereas out-patient services are available mainly in residential institutions and local community services centres.

Insured in-patient services include standard ward accommodation and meals; necessary nursing services; provision of routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; provision of medications, prosthetic and orthotic appliances that can be integrated to the human body, and of biological products and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital centre staff.

Out-patient services cover clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery care (day surgery); radiotherapy; diagnostic services; physiotherapy; ergotherapy; inhalation, audiology and speech therapies; orthoptics; and other services or examinations required under Quebec legislation.

Other services covered by insurance are mechanical, hormonal or chemical contraception; surgical sterilization (tubal ligation or vasectomy); and reanastomosis of the fallopian tubes or vas deferens; removal of tooth or root when the health status of the person requires or demands hospital services.

The Ministry of Health and Social Services administers an ambulance transportation program free of charge to persons aged 65 and over.

[1] Since October 1, 1992, extended-care hospitals and residential facilities have been included in a single institutional category (the CHSLD—*centres d'hébergement et de soins de longue durée*), although no change has been made to their specific missions.

Uninsured hospital services include cosmetic surgery; in vitro fertilization; private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services covered by the *Loi sur les accidents de travail et les maladies professionnelles* or other federal or provincial legislation.

Medical Care Plan

The services insured by the medical care plan, the régime *de soins médicaux*, include medical and surgical services provided by physicians, as well as oral surgery performed in hospital centres or in a university facility determined by regulation by dental surgeons and specialists in oral and maxillo-facial surgery.

The following services are not considered insured: any examination or service not related to a process of cure or prevention of illness; psychoanalysis in every form, unless such service is rendered in an institution authorized by the Ministry of Health and Social Services; any service provided for purely aesthetic purposes; any refractive surgery, except in cases where there is documented failure of more than 3.00 diopters or anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn; any consultation by telecommunication or by correspondence; any service rendered by a professional to the person's spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the person who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examination, vaccination, immunization or injections given to a group or for certain purposes; any service rendered by a professional based on an agreement or a contract with an employer, an association or an organization; any adjustment of eyeglasses or contact lenses; any surgical removal of a tooth or tooth fragment carried out by a physician, except in certain cases where the service is provided in a hospital centre; all acupuncture procedures; the injection of sclerosing substances and the examination made at that time; thermography, mammography used for screening purposes, unless this service is not delivered in a place designated by the Minister in either case, either to a recipient who is 40 or over and under 50 years of age and who presents a significant risk factor associated with breast cancer, and on condition that such an examination has not been performed on the recipient in the previous two years, or to a recipient 50 years of age or older, on condition that such an examination has not been performed on the recipient in the previous two years; mammography for detection purposes, tomodensitometry, magnetic resonance imaging, the use of radionuclides in vivo in a human, and ultrasonography, unless all these services are rendered in a hospital centre; any radiological or anaesthetic service provided by a physician if it is required with a view to dispensing an uninsured service, with the exception of a dental service provided in a hospital centre, or in case of a radiology, if it is required by a person other than a physician or a dentist; and any surgical service provided for the purposes of transsexualism unless such a service is provided upon the recommendation of a physician specialized in psychiatry and carried out in a hospital centre recognized to this end; and any services not associated with a pathology and that are rendered by a physician to a patient between the ages of 18 and 65 years, unless that individual is the holder of a claim card for colour-blindness or a refraction problem, for the purpose of obtaining or renewing a prescription for eyeglasses or contact lenses.

In addition to the basic insured services, the *Régie* also covers, with some limitations regarding certain residents of Quebec as

defined by the *Loi sur l'assurance maladie* and Employment Assistance recipients, optometric services; dental care for children and Employment Assistance recipients, and acrylic dental prostheses for Employment Assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids or other equipment for persons with physical disabilities; external breast prostheses; ocular prostheses; supplementary hearing aids and visual aids for people with visual or auditory handicaps; and permanent ostomy appliances.

Moreover, since January 1, 1997, in terms of drug insurance, the *Régie* covers over and above its regular clientele (Employment Assistance recipients and seniors 65 years and older), individuals who do not otherwise have access to a private drug insurance plan. The new drug insurance plan covers 3.2 million insured people.

Universality

Hospital Insurance and Medical Care Plans

Registration with the hospital insurance plan is not required. Registration with the *Régie de l'assurance maladie* or proof of residence is sufficient to establish eligibility. All residents or deemed residents of Quebec must be registered with the *Régie de l'assurance maladie* to be eligible for the health insurance programs. Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police, and inmates of federal penitentiaries are not covered by the Plan. No premium payment exists.

Portability

Hospital Insurance and Medical Care Plans

Minimum Residence

Insured persons moving to Quebec from other provinces or territories in Canada are entitled to coverage under the Quebec health insurance plan when benefits under the province or territory of origin cease, provided they register with the *Régie de l'assurance maladie*.

If outside Quebec for 183 days or more, students, and full-time unpaid trainees, can retain their status as a resident of Quebec in the first case for four consecutive calendar years at most, and in the second case for two consecutive calendar years at most. Quebec government civil servants, employees of non-profit organizations with head offices in Canada and employed abroad in assistance or cooperation programs recognized by the Minister of Health and Social Services, and the spouses and dependants of all such persons maintain their resident status, provided the *Régie* is notified of their absence.

This is also the case for persons living in another province for the purpose of seeking employment, holding temporary employment or working on contract, provided their families remain in Quebec or they retain a residence there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons employed or working on contract outside Quebec for a company headquartered in Quebec, or employed by the federal government and posted outside Quebec, also retain their resident status, provided their families remain in Quebec or they retain a residence there.

Resident status is also maintained by those persons who remain outside the province for 183 days or more, but fewer than 12 months within a calendar year, provided such an absence occurs only once every seven years and is reported to the Régie.

First-day coverage is provided to certain categories of residents, notably permanent residents under the *Immigration Act*, repatriated Canadians, returning Canadians, members of the Canadian Forces and Royal Canadian Mounted Police who have not acquired their resident status, and inmates of federal penitentiaries, upon release or discharge. Immediate coverage is also provided to persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for three months or more, or who are living in Quebec under an official bursary or internship program of the Ministry of Education.

Payment Arrangements in Canada

Hospital costs incurred in other provinces or territories are paid through reciprocal billing, an interprovincial agreement established between the provinces and territories. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or high-cost procedures are paid at approved standard interprovincial/territorial rates. However, since November 1, 1995, Quebec only reimburses the average rate of Outaouais specialized centres to Ottawa hospitals when an Outaouais resident is hospitalized for non-urgent care or services available in the Outaouais.

The costs of medical services incurred in other provinces or territories are reimbursed at the amount actually paid, or the rate that would be paid by the *Régie* for the same services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when specialized services are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 for the Abitibi-Témiscamingue/North Bay area.

Payment Arrangements Outside Canada

As of September 1, 1996, hospital services provided outside Canada in cases of emergency or sudden illness are reimbursed by the Régie, usually in Canadian funds, to a maximum of $100 Canadian per diem if the patient was hospitalized (including day surgery), or $50 per out-patient visit

However, haemodialysis treatments are covered to a maximum of $220 per treatment. In such cases, the *Régie* reimburses the associated professional services. Services must be dispensed in a recognized establishment accredited as a hospital or hospital centre by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Students, unpaid trainees, Quebec officials posted abroad, missionaries and employees of non-profit organizations working under programs of international aid or cooperation recognized by the Ministry of Health and Social Services, must contact the *Régie* in order to ascertain their eligibility. If the *Régie* recognizes them as having special status, they receive a full reimbursement for hospital cost in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the *Régie* up to the amount of the expenses actually incurred. All services insured in the province are covered abroad, usually in Canadian funds, at the Quebec rate.

Beneficiaries requiring medical services in hospital abroad for services unavailable in Quebec or elsewhere in Canada are reimbursed 100 percent with prior consent for medical and hospital services meeting certain conditions. Consent is not given if the hospital service is available in Quebec or elsewhere in Canada.

Permanent Moves out of the Province

Insured residents moving permanently to other parts of Canada are covered for up to three months after leaving the province.

Coverage is immediately discontinued as of the first day that insured residents move permanently to another country.

Accessibility

Hospital Insurance and Medical Care Plans

Reasonable Access
Everyone has the right to receive adequate health care services without any kind of impediment.

There is no extra-billing by physicians in the Province of Quebec. While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration in accordance with the provincial fee schedule; and non-participating professionals who practise outside the plan entirely, so that neither they, nor their patients, receive reimbursement from the Régie.

As of March 31, 2000, Quebec counted 124 institutions operating as hospital centres for a clientele suffering from serious diseases with 21,957 acute and psychiatric care beds allotted to these institutions. Moreover, from April 1, 1998, to March 31, 1999[2], hospital institutions counted more than 774,000 admissions for short-term stays and close to 283,000 registrations for day surgeries. These hospitalizations represented a total number of more than 6,386,447 patient-days.

Payment to Hospitals
The financing of a hospital centre by the Ministry of Health and Social Services is carried out through a system of payments in respect of the cost of insured services provided.

The payments transferred in 1998-1999** to institutions operating as hospital centres for insured health services for Quebec residents have amounted to $5.23 billion and payments transferred to hospital centres outside Quebec amounted to approximately $76,018,000.

System of Payment for Medical Care
Physicians are paid in accordance with a negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient in accordance with the fee schedule after the patient has collected from the Régie. Non-participating physicians are paid directly by the patients according to the amount charged.

Reasonable Compensation

Provision is made in law for reasonable compensation for all insured health services rendered by health care professionals. The Minister may enter into an agreement with the organizations representing any class of professionals in the health care field, prescribing a different remuneration for medical services where the number of professionals is insufficient. The Minister may also provide a

[2] Latest year for which figures are available.

different remuneration for physicians during the first years of practice or specialty according to the territory of practice and the nature of activities. These provisions are preceded by consultation with organizations representing health care professionals.

In 1999-2000, the *Régie* had paid $2.626 billion to doctors in the province and the amount evaluated for medical services outside the province had reached $9 million.

Extended Health Care Services

Nursing home intermediate care, adult residential care and home care services are available with admission coordinated through a regional admission system and based on a single assessment tool. Local community services centres *(centres locaux de services communautaires)* receive individuals, evaluate their care requirements and either arrange for the provision of such services as day-centre programs or home care, or refer them to the appropriate agency.

Some home care services are offered by the provincial Ministry of Health and Social Services, including nursing care and assistance, homemaker services and medical surveillance.

Residential facilities and long-term care units in short-term care hospitals focus on the maintenance of autonomy and functional capacities of their clients by providing a variety of programs and services, including health care services.

Ontario

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is established under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services in hospitals and health facilities, by physicians and by other health care practitioners. The health program is administered on a non-profit basis by the Ministry of Health and Long-Term Care (see section 10 of the *Health Insurance Act*).

1.2 Reporting Relationship

OHIP does not prepare a specific report for the Minister of Health and Long-Term Care. The Ministry prepares an Annual Business Plan that includes the Ontario Health Insurance Plan, which includes OHIP's activities.

1.3 Audit of Accounts

OHIP's accounts and transactions are audited by the Provincial Auditor and are published annually in the Public Accounts of Ontario.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services in Ontario are governed by the *Health Insurance Act*, and Regulation 552 under that Act. The Act and Regulations define insured services on both in-patient and out-patient bases.

The *Public Hospitals Act* is the enabling legislation for public hospitals in Ontario and includes Regulation 964 on the Classification of Hospitals and Regulation 965 on Hospital Management.

In 1999-2000, there were 182 hospitals staffed and in operation in the Province, including 154 acute care hospitals, 21 chronic care hospitals, four general and special rehabilitation hospitals, and three specialty hospitals. The above facilities are categorized by major activity; however, facilities provide a mix of hospital services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation and so on. Public hospitals are accredited by the Canadian Council on Health Services Accreditation (CCHSA).

Insured in-patient hospital services include accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations; use of operating rooms, obstetrical delivery rooms and anaesthetic facilities.

Insured out-patient services include laboratory, radiological and other diagnostic procedures; use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available; use of diet counseling services; use of home renal dialysis and home hyperalimentation equipment, supplies and medication; provision of equipment, supplies and medication to haemophiliac patients for use at home; cyclosporine to transplant patients; zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection; biosynthetic human growth hormone to patients with endogenous growth hormone deficiency; drugs for treatment of cystic fibrosis and thalassemia; erythropoietin to patients with

anaemia of end-stage renal disease; alglucerase to patients with Gaucher disease; and clozapine to patients with treatment-resistant schizophrenia. A visit to a hospital for the administration of a rabies vaccine is an out-patient service to which an insured person is entitled without charge.

Uninsured hospital services include additional charges for preferred accommodation unless prescribed by a physician; telephones; televisions; charges for private-duty nursing; cosmetic surgery under most circumstances; provisions of medications for patients to take home from hospital, with certain exceptions; and hospital visits solely for the administration of drugs, subject to certain exceptions.

In addition to the insured hospital benefits, Ontario provides long term care services, mental health services, including the operation of provincial psychiatric hospitals, the residential component of the Homes for Special Care Program, ambulance services (air and land) with a patient co-payment component, dental treatments for patients with clef lip/palate registered at a designated clinic, and funding for a Breast Cancer Screening Program.

When insured physician services are provided in licensed facilities outside hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, the Ministry provides funding through the payment of facility fees under the *Independent Health Facilities Act* (IHFA). Under the IHFA, patient charges for facility fees are prohibited. Facility fees cover the cost of premises, equipment, supplies and personnel used to render an insured service, where these costs are not included in the physician's fee. Examples of facilities that are licensed under the IHFA include surgical/ treatment facilities (providing abortions, cataract surgery, dialysis, plastic surgery, etc.) and diagnostic facilities (providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies).

Facility fees are to be charged only to the government by facilities that are licensed under the *Independent Health Facilities Act*. New facilities are ordinarily established through a request for proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

OHIP, established under the *Health Insurance Act*, provides for the payment of insured services delivered by physicians and other health care practitioners and insured services rendered in hospitals and in and by certain health facilities. The insured health program in Ontario is established under the *Health Insurance Act* to provide insurance in respect of the cost of services in hospitals and health facilities, by physicians and by other health care practitioners. OHIP is administered on a non-profit basis by the Ministry of Health and Long-Term Care. Under section 37(1) of Regulation 552 in the *Health Insurance Act*, a service rendered by a physician in Ontario is an insured service if it is referred to in the schedule of benefits and rendered in such circumstances or under such conditions as are specified in the Schedule of Benefits.

Physicians are registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario. There are approximately 20,000 physicians registered to submit claims to the Ontario Health Insurance Plan.

Physicians may submit claims directly to OHIP for all insured services rendered to insured persons, or they may bill the insured person directly for all uninsured services as specified in section 15 of the *Health Insurance Act* (see also the *Health Care Accessibility Act*). Physicians who do not bill OHIP directly are commonly referred to as "opted out". The percentage of opted out physicians has fallen to approximately one percent since the enactment of the *Health Care Accessibility Act* in 1986.

Insured physician services in facilities, physicians' offices or in a patient's home include diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anæsthesia; radiology and laboratory services in approved facilities; and immunizations, injections and tests. Insured physician services are detailed in the Schedule of Benefits, pursuant to Ontario Regulation 552 under the *Health Insurance Act*.

Services are added to or deleted (de-insured) from the Schedule of Benefits for Physician Services on the recommendation of the Central Tariff Committee of the Ontario Medical Association in consultation with the Ministry of Health and Long-Term Care. The Schedule of Benefits Working Group, comprised of members from the Ontario Medical Association and the Ministry, review the Schedule of Benefits on a regular basis. Public consultation may also be undertaken. Services are added to or deleted from the Schedule of Benefits for Physician Services by regulation.

2.3 Insured Surgical-Dental Services

Approximately 350 dentists and dental/oral surgeons provided insured surgical-dental services.

Insured hospital surgical-dental services include repair of traumatic injuries; surgical incisions; excision of tumours and cysts; treatment of fractures; homeografts; implants; alloplastic reconstructions and all other specified dental procedures where it is medically necessary that they be rendered in hospital. Insured hospital surgical-dental services are prescribed in section 16 and Schedules 13, 14, and 15 of Regulation 552 under the *Health Insurance Act*.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Insurance Act* and Regulations are insured. All other services are uninsured. Section 24 of Regulation 552 contains a non-exhaustive list of services, which are prescribed as uninsured.

Uninsured hospital services include additional charges for preferred accommodation unless prescribed by a physician; telephones; televisions; charges for private-duty nursing; cosmetic surgery under most circumstances; provisions of medications for patients to take home from hospital, with certain exceptions; and in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

Uninsured physician services include services that are not medically necessary; travelling to visit an insured person outside the area of the practice; toll charges for long-distance telephone calls; preparing or providing a drug, antigen, antiserum or other substance; advice given by telephone at the request of the insured person or the person's representative; an interview or case conference; preparation and transfer of records at the insured person's request; a service that is received wholly or partly for the production or completion of a document or the transmission of information in specified circumstances; the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances; provision of a prescription when no concomitant insured service is rendered; cosmetic surgery; acupuncture procedures; psychological testing; group screening programs; and research and survey programs. This is not exhaustive and is subject to exceptions. (Refer to section 24 of Regulation 552 under the *Health Insurance Act*, the Schedule of Benefits for Physician Services, and section 11.2 of the *Health Insurance Act*).

Furthermore, section 11.2(2) of the *Health Insurance Act* provides that services to which a person is entitled under the *Workplace Safety and Insurance Act* (1992), or under the *Homes for Special Care Act* or under any Act of the Parliament of Canada, except the *Canada Health Act*, are not insured services.

The Ministry of Health and Long-Term Care, through the OHIP program, acts as a payment agency for Workers Safety and Insurance Board (WSIB) claims. Physicians submit WSIB claims directly to OHIP for payment using a WSIB code on the claims. The physicians are paid directly by the Ministry of Health and Long-Term Care, which is then reimbursed by WSIB.

"Third-party requests" for services are not generally insured by OHIP. Because third-party services are not medically necessary, they do not take priority over access to insured services.

Ontario's health insurance policy states that enhanced medical goods, such as fibreglass casts, are provided to the patient, without charge, where those enhanced medical goods are medically necessarily.

It is a provincial offence for a physician to charge patients or to accept payment from patients for more than the amount payable by OHIP. A physician may charge for services that are not insured under OHIP. The Ministry does not regulate charges for uninsured services as these charges are governed by the College of Physicians and Surgeons of Ontario. The Ontario Medical Association publishes a schedule of suggested fees for uninsured services.

3.0 Universality

3.1 Eligibility

With certain exceptions, all residents of Ontario are eligible for coverage, subject to a three-month waiting period. Regulations under the *Ontario Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are subject to the three-month waiting period (refer to section 11(1) of the *Health Insurance Act* and Regulation 552 thereunder.)

Every resident of Ontario is required to register for health insurance coverage. To be considered a resident of Ontario for the purpose of obtaining OHIP coverage, a person must:

- hold prescribed citizenship or immigration status (s 1.1(1) of Regulation 552, under the *Health Insurance Act*);
- make his or her permanent and principal home in Ontario in accordance with Regulation 552; and
- be present in Ontario for at least 153 days in any 12-month period.

Changes to Regulation 552 of the *Health Insurance Act*, effective March 1, 1999, reduced the residency requirement for OHIP coverage from 183 to 153 days in any 12-month period. The Ministry of Health and Long-Term Care also incorporated provisions for extended out-of-country absences. For further information about extended absences, see sections 4.2 and 4.3.

Effective March 1, 2000, amendments to Regulation 552 of the *Health Insurance Act* resulted in the application of new definitions of common-law spouse and same-sex partner to the OHIP eligibility sections of the Regulation.

The addition of the definitions allows same-sex partners to access the same benefits as common-law spouses. However, since OHIP eligibility is granted on an individual basis, the number of policies affected is small. Specifically, same-sex partners and common-law spouses are now eligible for continuous OHIP eligibility when accompanying their common-law spouses or same-sex partners on some types of extended absences. Same-sex partners and common-law spouses of foreign workers and foreign clergy may also be eligible for Ontario health coverage when accompanying their spouses or partners.

Persons previously ineligible for coverage but whose status has changed (e.g., change in immigration status, discharge from the Canadian Armed Forces or RCMP, or release from a federal penitentiary) may, upon application, be eligible for OHIP coverage.

With certain exceptions set out in sub-section 3(4) of Regulation 552, most new and returning residents are subject to a three-month waiting period. The Ministry will determine whether or not an individual is subject to a three-month waiting period upon application. Former federal inmates, discharged members of the Canadian Armed Forces or RCMP, and newly determined convention refugees are among those who are exempt from the waiting period.

3.2 Registration Requirements

A health card is issued to residents upon application to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing permanent residence in the Province. Registration is done through local OHIP offices.

Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide the Ministry with proof of immigration status, residency and identity. Original documents from each category are to be provided by the applicants upon registration. Once eligibility has been determined, applicants over the age of 15½ are generally required to have their photographs and signatures captured for their photo Health Card.

Each photo Health Card has a card renewal/ expiry date in the bottom right-hand corner of the card. The Ministry mails renewal notices to registrants approximately six weeks before the card's renewal date.

The Ontario Ministry of Health and Long-Term Care is the sole provider of coverage for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service covered by OHIP.

Approximately 11,700,000 Ontario residents were registered with OHIP as of March 31, 2000.

3.3 Other Categories of Individual

Ontario's Ministry of Health and Long-Term Care provides coverage to several categories of individuals other than Canadian citizens and landed immigrants. Generally, these individuals are required to provide proof of citizenship or acceptable immigration status, residency and identity in the same manner as individuals with permanent resident status who apply for Ontario health coverage. However, applicants from within these categories may also be required to provide specific documentation to confirm their entitlement to OHIP coverage or they may be exempted from certain requirements. A general overview of eligibility for applicants in other categories is included below.

The following categories of individuals will be eligible if they otherwise meet the definition of resident in Regulation 552:

Applicants for Landing (AFL) - Applicants for Landing are persons who are being processed toward landing by Citizenship and Immigration

Canada (CIC) and, generally speaking, have met CIC medical requirements. An immigrant who has been "landed" is a permanent resident of Canada. Approximately 4,500 individuals were registered as Applicants for Landing as of March 31, 2000.

Convention Refugees - The Immigration and Refugee Board designates a person as a Convention Refugee when the person has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion. Approximately 67,400 individuals were registered as Convention Refugees as of March 31, 2000.

Minister's Permit Holders - Holders of Minister's Permits are persons who do not meet immigration requirements to remain permanently in Canada. Holders of case types 80 (adoption only), 86, 87, 88, or 89 Minister's Permits who are ordinarily residing in Ontario are eligible for OHIP coverage for the duration of their immigration documents. Holders of case type 90 Minister's Permits are not eligible for OHIP. Approximately 1,100 individuals were registered as holders of eligible Minister's Permits as of March 31, 2000.

Foreign Workers, Clergy, and their Accompanying Family Members - An eligible foreign clergy-person is a person who is a member of any denomination of clergy who has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months and who is ordinarily a resident of Ontario. Approximately 1,100 individuals were registered as eligible foreign clergy as of March 31, 2000.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer situated in Ontario and has been issued by Citizenship and Immigration Canada an Employment Authorization that names the Canadian employer, states the person's prospective occupation, and has been issued an Employment Authorization for a period of at least six months. Approximately 10,000 individuals were registered as eligible foreign workers as of March 31, 2000.

Eligible accompanying family members are the spouses and/or dependent children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker who is to be employed for at least three consecutive years and who is ordinarily a resident of Ontario. Approximately 7,000 individuals were registered as eligible accompanying family members as of March 31, 2000.

Migrant Farm Workers - Migrant farm workers are persons who have been issued an Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by Citizenship and Immigration Canada. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period. Approximately 2,400 individuals were registered as migrant farm workers as of March 31, 2000.

3.4 Premiums

The payment of premiums was abolished in 1990.

4.0 Portability

4.1 Minimum Waiting Period

Individuals who move to Ontario and who were previously insured by another Canadian province or territory are entitled to OHIP coverage beginning the first day of the third month after establishing residency in Ontario. New or returning Ontario residents who were not previously insured by another province or territory's health plan are entitled to coverage three full months after establishing residency in Ontario.

These requirements are set out in section 3 of Regulation 552.

4.2 Coverage During Temporary Absences In Canada

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability. In accordance with that agreement, insured residents who are outside Ontario temporarily can use their Ontario Health Card to obtain insured health services. Insured residents who leave Ontario temporarily to travel within Canada without establishing residency in another province or territory will continue to be covered for a period of up to 12 months.

Out-of-province services are covered under sections 28(1), 30(1) and 32 of Regulation 552 of the *Health Insurance Act*. It is also possible for Ontario residents to maintain continuous health coverage while working or studying in another Canadian province or territory temporarily.

A person insured by OHIP who seeks or accepts employment in another province or territory is provided with OHIP coverage for a maximum of 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where he or she has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health coverage for the duration of their studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, students should provide the Ministry with a letter from their educational institutions confirming registration as full-time students. Family members of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying a student for the duration of his or her studies.

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the Plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Coordinating Committee on Reciprocal Billing.

In addition, section 28 of Regulation 552 of the *Health Insurance Act* sets out payment for insured hospital services outside Ontario but within Canada, which are not billed through the reciprocal arrangements.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services.

4.3 Coverage During Temporary Absences Outside Canada

Coverage during temporary absences outside Canada is governed by sections 28.1 through 32 (inclusive) of Regulation 552.

In accordance with sections 1.1(3), (4), 1.1(5) and 1.1(6) of Regulation 552 of Ontario's *Health Insurance Act*, the Ontario Ministry of Health and Long-Term Care may provide insured Ontario residents with continuous OHIP eligibility for absences of longer than 212 days in a 12-month period. In most cases, applicants must provide the Ministry with a document explaining the reason for their absence from Ontario to qualify for an approved absence. Applicants must also have been present for at least 153 days in each of the two consecutive 12-month periods prior to the expected date of departure in order to be approved for an extended absence.

Approved absences vary in duration depending on the reason for the absence.

Reason	OHIP coverage
Study	Duration of a full-time academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/ Other	Up to two years in a lifetime

Family members may also qualify for continuous OHIP eligibility while accompanying the primary applicant on an approved absence and should contact their local OHIP office for details.

Out-of-country services are covered under section 28.1 to 28.6 inclusive, and section 29 of Regulation 552 of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- a maximum $400 Canadian for in-patient services;
- a maximum $50 Canadian for out-patient services; and
- a maximum $210 Canadian per dialysis treatment.

Medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) as well as laboratory tests required on an emergency basis, are reimbursed only at the rates listed in the Ontario Ministry of Health and Long-Term Care's Schedule of Benefits, Regulation 552, or the amount billed, whichever is less. Charges for medically necessary emergency out-of-country in-patient and out-patient services are reimbursed only when rendered in a hospital or licensed health facility.

In 1999-2000, total payments for out-of-country in-patient and out-patient insured hospital services amounted to $17.0 million.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided out-of-country. These provisions are set out in section 28.4 of Regulation 552.

Under section 28.4 of Regulation 552, where medically accepted treatment is not available in Ontario, or in those instances where the patient is threatened in terms of life or irreversible tissue damage, the patient may be entitled to full Ministry funding of out-of-country health services.

There is no formal prior approval process for services provided to Ontario residents outside the province but within Canada. The interprovincial agreement between the provinces includes a schedule for high-cost services. In rare circumstances where this schedule does not cover the costs in another province, Ontario may be asked to guarantee payment before the service is provided.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, medical and dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and medical services, as defined in the *Health Insurance Act*. Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured. Under the *Health Care Accessibility Act*, physicians are prohibited from charging more than the amount for an insured service than is allowed in the Schedule of Benefits for Physician Services. Extra-billing by physicians is also prohibited. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

The Ministry of Health and Long-Term Care implemented Health Number/Care Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to the Ministry a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 1999-2000, there were 168 public hospitals staffed and in operation in the Province, including chronic care hospitals, general hospitals and special rehabilitation units. There were 6,645,272 acute patient days and 2,456,823 chronic patient days and 603,724 rehabilitation patient days delivered by public hospitals during fiscal year 1999-2000.

The Ministry also provided hospitals with over $130 million directed toward increasing the number of nursing positions (both RN and RPN) in 1999-2000.

5.3 Access to Insured Physician and Dental-Surgical Services

Reasonable access to physician services in Ontario is ensured by an adequate supply of physicians.

An Underserviced Area Program provides residents of rural and remote areas of the Province with improved access to general physician services. Four programs enhance access to health services for residents of northern Ontario: the Northern Group Funding Plan (NGFP) and Community Sponsored Contracts (CSC) provide alternative funding arrangements that pay a group of physicians a global amount for primary care services (not fee-for-service); the Incentive Grant Program for physicians provides financial assistance to general practitioners and specialists locating to a designated underserviced area; and the Northern Health Travel Grant financially assists patients who must travel to receive hospital and specialist medical services.

Currently, there are 100 communities in Ontario designated as underserviced for General/Family Practitioners and 11 communities designated as underserviced for Specialists. According to the *"Physicians in Ontario 1999"* report prepared by Dr. McKendry and the Ontario Physician Human Resource Data Centre, there are 9,807

General/Family Practitioners and 10,673 Specialists in Ontario.

As of December 1999, there were approximately 20,480 active physicians, most of whom provided insured physician services in Ontario. Of this total 9,807 (47.9 percent) were family physicians and 10,673 (52.1 percent) were Specialists.

Several measures were taken in 1999-2000 to ensure that the distribution of these physicians was more equitable across the Province. In response to the McKendry Report, the Ministry of Health and Long-Term Care announced on December 22, 1999, that it would implement Dr. McKendry's short-term recommendations as well as form an Expert Panel on Health Professional Human Resources to address medium and long term strategies. The Ontario Government has committed to providing $11 million for the following short-term initiatives:

- funding for up to 15 additional postgraduate training positions in Ontario to recruit back Canadian medical school graduates who have taken their postgraduate training in the United States and require further training to meet Canadian standards and requirements. These positions are targeted to underserviced areas and specialties;
- expanding the International Medical Graduate Program by 50 percent, from 24 to 36 positions, and targeting all new entry positions to underserviced areas and specialties;
- doubling the number of community development officers (from three to six) to help underserviced areas recruit doctors to their communities;
- expanding the two Northern family medicine residency-training programs by increasing the number of entry training positions by 25 percent (from 24 to 30), and by more than doubling the number of third-year advanced-training family medicine positions in areas such as anaesthesia, obstetrics and emergency medicine (from 6 to 12); and
- expanding the Ministry's Re-entry/Training/ Return of Service Program by 15, from 25 to 40 positions.

Some recent initiatives that were announced in the early part of the 2000-2001 fiscal year to enhance access to physician services include providing free tuition and a location incentive to medical students and residents who agree to practice in underserviced areas for a minimum of three years, and an initial increase in undergraduate medical school enrolment of 40 positions for the fall 2000 academic year. This increase brings the total number of entry positions to 572 from 532 across five medical schools.

5.4 Physician Compensation

Insured services provided by 20,000 physicians and 350 dentists in the Province are paid primarily on a fee-for-service basis, according to the Schedules of Benefits for Physician Services under the *Health Insurance Act*.

In 2000, the Government of Ontario concluded a four-year agreement with the Ontario Medical Association (OMA) to determine funding amounts for physician services. In 1999-2000, fee-for-service physician services were paid $4.3 billion. A Schedule of Benefits Working Group, composed of Ministry of Health and Long-Term Care and OMA representatives, reviews items in the Plan's Schedule of Benefits and reports to the joint Ministry/OMA Physician Services Committee.

The independent Resource-Based Relative Value Schedule Commission was established in 1997 with a mandate to provide recommendations regarding a new relative value fee schedule for physician services. A draft schedule and a report are to be ready for discussion in Spring 2001. A final schedule will be prepared after consultations.

Representatives of government and the Ontario Dental Association negotiate agreements on adjustments to the Plan's Schedule of Benefits that cover insured dental services provided in hospital. In 1999-2000 the dental expenditures were $8.1 million. The last funding agreement expired on March 31, 2000, and was extended to March 31, 2001. Discussions for a new multi-year agreement commenced in fall 2000.

5.5 Payments to Hospitals

Hospitals submit annual Operating Plans that are the product of a broad consultation within the facilities (all levels of staff, unions, physicians, board and so on) and within the community and region. The Operating Plan is first and foremost a planning document but has a substantial budget component, both financial and statistical. The District Health Council (DHC) and staff of the Ministry of Health and Long-Term Care then review this Operating Plan. The Ministry review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarifications with the facility.

Payments made by the health care plan to hospitals for insured services come under the *Health Insurance Act* and are calculated on an annual budget basis. The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority programs, and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

Payments for services rendered in independent health facilities are governed by the *Independent Health Facilities Act*.

Chronic care co-payment regulations and rates are revised annually following changes in the Canada Pension Plan (CPP).

Priority programs are diverse and require highly specialized human resources and infrastructure. They include:

Acquired Brain Injury; Cancer, Cardiac Services; Cochlear Implants; Cleft Lip and Palate Dental Program; End Stage Renal Disease; Genetics Services (Cytogenetic Labs, Maternal Serum Screening, Molecular/DNA Labs); HIV/AIDS Clinics; Imaging (MRI); Maternal Newborn Services; Orthopaedic Hip and Knee Implants; Regional Geriatric Program; Stroke; Sexual Assault Treatment Centres; Transplants (solid organ, bone marrow); and Trauma Centres.

The programs are often high cost and high growth. They can be associated with newly developed treatments that include advanced therapies and technologies. Generally, these programs are managed provincially and are designed to ensure equitable access. The Ministry determines funding based on population needs and clinical outcome evidence.

The Ministry measures and rewards relative cost efficiency in hospitals through the Equity Funding Methodology. Payments are made to those hospitals that spend less than expected, with consideration given to the individual characteristics of the hospital.

In addition, specialized methodologies are used for incremental funding for specific policy/program initiatives (i.e. Nursing Enhancements, 60-hour Post Partum Guarantee Length of Stay).

Funding for patient care in hospitals increased by almost $400 million in 1999, bringing the total funding for hospitals to $7.5 billion from $7.1 billion in 1998-1999. A portion of this additional reinvestment allowed hospitals to address Y2K remediation and transitional pressures. Year-end funding of $225 million created a shift in the surplus/deficit position in many hospitals.

6.0 Recognition Given to Federal Transfers

The federal contribution under the Canada Health and Social Transfer has been mentioned in Ontario's communications in the past year.

7.0 Extended Health Care Services

Extended health care, funded by the Ministry of Health and Long-Term Care, is provided by nursing homes, homes for the aged (long term care facilities) and home care service providers. The Ministry participates in the compliance monitoring process for long term care facilities in many ways. It provides dietary, environmental and medical consultation services within facilities; reviews health, safety, building and dietary standards and monitors how these standards are met; and assists in the development of corrective action plans, where necessary.

Home care services (professional services, personal support and homemaking services) are funded by the Ministry and provided through Community Care Access Centres for people of all ages. The Ministry funds attendant services for physically disabled adults and supportive housing services for seniors, physically disabled adults, adults with acquired brain injuries and persons living with HIV-AIDS. The Ministry also funds a variety of community support services such as adult day programs, meal services, and transportation services.

In addition to insured hospital benefits, Ontario provides the following: long-term care services; mental health services that include the operation of provincial psychiatric hospitals, community-based mental health treatment and support services; the residential component of the Homes for Special Care Program; air ambulance with a patient co-payment; dental treatments for patients with cleft lip/palate registered at a designated clinic; and funding for a Breast Cancer Screening Program.

Manitoba

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan is administered by the Department of Health under The *Health Services Insurance Act*, R.S.M. 1987, .c. H35. The Act was significantly amended in 1992 dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to the Department of Health. The dissolution took effect as of March 31, 1993.

The Manitoba Health Services Insurance Plan is administered under this Act for insurance in respect of the costs of hospital and medical services and other health services referred to, or shortly described, in Acts of the Legislature or regulations made thereunder.

The Minister of Health is responsible for the administration and operation of the Plan. Under section 3(2), the Minister has the power:

- to provide insurance for residents of the Province in respect of the costs of hospital services, medical services and other health services, and personal care;
- to plan, organize and develop throughout the Province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the Province;
- to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the Minister considers necessary to ensure that adequate standards are maintained;
- to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the Province or to make such arrangements as the Minister considers necessary to ensure that such a consulting service is provided;
- to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals required by the Government of Canada are submitted; and
- in cases where residents do not have available medical services and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents.

The Minister may also enter into contracts and agreements with any person or group of persons the Minister considers necessary for the purposes of the Act. He or she may also make grants to any person or group of persons for the purposes of the Act on such terms and conditions as considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to have an annual report prepared, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of *The Health Services Insurance Act* requires that the Provincial Auditor (or another auditor designated by the Provincial Auditor) audit the accounts of the plan annually and prepare a report of that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 1998-1999 fiscal year and is contained in the *Manitoba Health Annual Report 1998-1999.*

2.0 Comprehensiveness

2.1 Insured Hospital Services

Sections 46 and 47 of *The Health Services Insurance Act,* as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93) provide for insured hospital services.

As of March 31, 2000, there were 99 facilities in Manitoba providing insured hospital services to both in-patients and out-patients. Hospitals are designated by regulation under *The Health Services Insurance Act.*

Services specified by regulation as insured in-patient and out-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologics and related preparations; routine medical and surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situation. Manitoba Health is sensitive to new developments in the health sciences and the progression from basic and clinical research to the advancement of new treatments and services for general use in patient care. The timely introduction of a new service to the health system is assured by the combination of scientific evidence from leading researchers and clinicians and the advice received from public/patient advocacy groups.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (Regulation 49/93) made under *The Health Services Insurance Act.*

Physicians providing insured services in Manitoba must be lawfully entitled to practice medicine in Manitoba, registered and licensed under *The Medical Act.* As of March 31, 2000, there were 2,036 medical practitioners on the Manitoba Health Registry.

A medical practitioner, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with The *Health Services Insurance Act* and regulations. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Prior to rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible to submit a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all personal health care services to an insured person by a medical practitioner that are medically required and are not excluded under the Excluded Services Regulation (Regulation 46/93) under *the Health Services Insurance Act*. During fiscal year 1999-2000, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of services covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with the latter. Manitoba Health or a Regional Health Authority can also initiate this process. The process is managed by Manitoba Health and public consultation may be used on occasion.

2.3 Insured Surgical-Dental Services

Insured surgical-dental services are listed in the Dental Services in Hospital Schedule of the Hospital Services Insurance and Administration Regulation (Regulation 48/93) under The *Health Services Insurance Act*. These services are insured when performed by a certified oral or maxillofacial surgeon or a licensed dentist (registered and licensed under *The Dental Association Act*) in a hospital, when in the opinion of the surgeon or dentist, hospitalization is required for the proper performance of the procedure. The basis for hospitalization is determined by dental necessity, the medical status of the patient, or both. As of March 31, 2000, there were 550 dentists registered with Manitoba Health, of which only 105 received payments for insured services.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as medical practitioners and cannot charge to or collect from an insured person a fee in excess of the benefits payable under the Act or Regulations. There were no opted out providers of dental services as of March 31, 2000.

In order for a dental service to be added to the list of services covered by the latter, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA will negotiate the item, including the fee, with Manitoba Health. The latter or a Regional Health Authority can also initiate this process. The process is managed by Manitoba Health and public consultation may be used on occasion.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured medical services include examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties; group immunization or other group services except where authorized by Manitoba Health; services provided by a medical practitioner, dentist, chiropractor or optometrist to him or herself or any dependants; preparation of records, reports, certificates,

communications and testimony in court; mileage or travelling time; services provided by psychologists, chiropodists and other practitioners not provided for in the legislation; *in vitro* fertilization; tattoo removal; contact lens fitting; reversal sterilization procedures and psychoanalysis.

The *Health Services Insurance Act* states that hospital in-patient services include routine medical and surgical supplies, therefore reasonable access is available for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

To de-insure services covered by Manitoba Health the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 1999-2000.

3.0 Universality

3.1 Eligibility

The *Health Services Insurance Act* is the legislation that defines the eligibility of Manitoba residents for coverage under the health care insurance plan of the Province. Section 2(1) of the Act states that resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or a visitor, transient or tourist.

The Residency and Registration Regulation extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows for clergy, individuals with out-of-province employment, and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have an employment authorization of 12 months or more.

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival.

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civil War Pensions and Allowances Act*; *Government Employees Compensations Act*; *Merchant Seaman's Compensation Act*; *National Defence Act*; *Pensions Act*; *Royal Canadian Mounted Police Act*; *Veterans Rehabilitation Act* or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The exclusions include residents who are members of the Armed Forces, (the Royal Canadian Mounted Police) and federal inmates. These residents become eligible for Manitoba Health coverage upon ceasing to be a member of the Canadian Armed Forces; a member of the RCMP; or an inmate of a penitentiary who has no resident dependants. Upon change of status they have one month to register with Manitoba Health (Residency and Registration Regulation, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, of their intention to be physically present in Manitoba for six months, and provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a health card for that individual and all qualifying dependants.

Manitoba has two health-related numbers: the Registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all hospital and medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for the provincial drug program.

The number of residents registered with the health care insurance plan during 1999-2000 was 1,144,424.

There is no provision for a resident to opt out of the Manitoba health plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation, sub-section 8(1), requires that temporary workers be in possession of an Employment Authorization issued by Citizenship and Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and legally entitled to be in Canada before receiving Manitoba Health coverage.

In 1999-2000, 1,559 individuals with Employment Authorizations were covered under the Manitoba Health Services Insurance Plan.

The definition of resident under The *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada). Five individuals were covered under Minister's permits in 1999-2000.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation, section 6, identifies the waiting period for other insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arrival in Manitoba is entitled to benefits upon the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences In Canada

The Residency and Registration Regulation, subsection 7(1), defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies.

Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba upon completion of their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan

residents who receive care in a Manitoba border community. In addition, Manitoba has arrangements with two hospitals in Ontario and Saskatchewan for the provision of pediatric cardiac surgery.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient high-cost procedures and out-patient services are based on national rates agreed to by provincial or territorial health plans. This includes all medically necessary services as well as costs for emergency care.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 1999-2000, Manitoba Health made payments totalling approximately $11,350,493 for hospital services and $5,568,205 for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation, sub-section 7(1), defines the rules for portability of health insurance during temporary absences outside Canada.

Residents on a full-time employment contract outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba upon completion of their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for a period of up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba upon completion of their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation. Hospital services received outside Canada due to an emergency or sudden attack of illness, while temporarily absent, are paid as follows: In-patient services are paid based on a per diem rate according to hospital bed size:

- 1 - 100 beds: $280
- 101 - 500 beds: $365
- over 500 beds: $570

Out patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in the rural and urban areas.

Medically necessary hospital services, unavailable in Manitoba or elsewhere in Canada, and provided as a result of a recommendation by an appropriate specialist who has received the approval of Manitoba Health, are paid at no less than 100 percent of the equivalent Manitoba rate or 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds.

Physician services are covered in cases of emergency or sudden attack of illness and for elective services provided as the result of a recommendation by an appropriate specialist who has received the approval of Manitoba Health. Payment is made in Canadian funds at the same rate a Manitoba physician would receive for a similar service.

Manitoba Health made payments totalling approximately $1,933,606[1] for hospital care provided in hospitals outside Canada in the 1999-2000 fiscal year. In addition, Manitoba Health made payments totalling approximately $520,712[2] for medical care.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for services provided in other provinces or territories. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval.

[1] This figure does not include the amount paid for exchange on U.S. claims.

[2] This figure does not include the amount paid for exchange on U.S. claims paid under the Critical Shortages Fund.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Out-Patient Services in Surgical Facilities Regulation (M.R. 222/98) under The *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees in relation to insured medical services.

5.2 Access to Insured Hospital Services

As of March 31, 2000, Manitoba had a total of 3973 acute care set-up beds and 728 other set-up beds (psychiatric extended treatment, palliative, chronic, long term assessment/ rehabilitation and panelled) to serve a population of 1,144,424.

Winnipeg, with 56.6 percent of the population, has 2,234 acute care set-up beds and 433 other set-up beds. In addition, there are two hospitals that provide long term care and one adolescent psychiatric facility.

In rural Manitoba there are 1,739 acute care set-up beds and 295 other set-up beds, plus two federal hospitals and 22 federal nursing stations. In addition, rural Manitoba residents have access to Winnipeg acute care set-up beds.

As in other provinces, Manitoba Health is experiencing a shortage of nurses in specific practice and geographic settings. (e.g., northern, remote and critical care). Manitoba does, however, have one of the

higher registered nurse-to-population ratios in the country (89.1 registered nurses per 10,000 population, CIHI, 2000).

Manitoba also has a wide range of other health care professionals, although there are shortages in some of the technology fields, (e.g., radiation therapists and ultrasound technologists). However, the numbers of health care professionals employed in these fields in Manitoba is small, and shortages can usually be addressed through recruitment strategies.

Manitoba currently has access to three Magnetic Resonance Images (MRI) machines for clinical testing. All units are located in Winnipeg. The first unit was installed in 1990 by the St. Boniface Research Foundation and replaced in October 1998. The second MRI unit is located at Health Sciences Centre and became operational in September of 1998. This unit was installed in conjunction with the National Research Council (NRC). The third MRI unit, located in Winnipeg, became operational in January 2000.

There is one additional MRI machine located at the St. Boniface General Hospital Research Foundation that is utilized for research purposes only. This unit is smaller that the others, and only scans the head. As no clinical patient testing occurs on this machine, no operating dollars are provided by Manitoba Health.

Manitoba has 11 Computerized Tomography (CT) Scanners – Health Sciences Centre (2), St. Boniface General Hospital (2), Victoria General Hospital, Dauphin Regional Health Centre, Brandon Regional Health Centre, Misericordia, Seven Oaks, Grace and Concordia Hospitals. As well, there are 56 ultrasound scanners within Winnipeg Health Facilities, plus another 23 ultrasound machines located in rural and northern regions. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

The Province is in the process of implementing a five-point plan to improve access for insured hospital services. This plan includes the provision of funding to open up to 100 new beds in Winnipeg, Brandon and Thompson; improving admission and discharge procedures such as expanded emergency fast track, increased emergency psychiatric nurse coverage, and additional geriatric program assessment teams; expanding community based services like the Community Intravenous Therapy Program, strengthening prevention programs like the flu immunization program, and increasing the capacity of the home care program, and the adult day program.

In 1999-2000, there was some expansion of diagnostic imaging services into rural regions such as CT in Dauphin. As well, funding was approved for the expansion to the community cancer program to include Neepawa and two satellite community cancer programs, one in Russell and the other in Hamiota.

The breast health centre offers a full range of diagnostic and assessment services in one location, including diagnostic mammography, ultrasound – dedicated to breast service, stereotactic core biopsy and surgical consultation. This centre provides individual and family education, risk assessment, referral services and genetic counselling, and will facilitate laboratory testing of women who are deemed at high risk for breast cancer.

There was a net increase of 224 personal care home beds across the Province during 1999-2000. The opening of these beds helped to relieve the bed pressure in the acute care facilities. Measures taken in 1999-2000 to achieve more appropriate waiting times for insured hospital services include the purchase of new equipment such as a bone density scanner; extended hours of operation of some specialty equipment such as MRI; the creation of a nursing fund to assist in retaining and recruiting nurses through aggressive recruitment, direct incentives and increased access to education programs; the

establishment of a fund for the recruitment and retention of medical specialists; and the consolidation of the cardiac surgery waiting list.

5.3 Access to Insured Physician and Dental-Surgical Services

In 1999-2000, Manitoba Health undertook several initiatives to improve access to physicians. Physician shortage in rural and remote areas of the Province is a chronic problem. Manitoba has initiated a Rural Physician Action Plan that will see improved recruitment of rural students into medicine, increased training opportunities for medical students and residents in rural communities, and strong infrastructure support for continuing medical education.

In addition, Manitoba has supported employers to recruit new physicians to the Province, in particular in some of the medical and surgical specialties where shortages were acute. Manitoba experienced a net gain of seven physicians this year. Plans are underway for 2000-2001 to introduce new retention initiatives.

5.4 Physician Compensation

In 1998, Manitoba and the Manitoba Medical Association (MMA) entered into an Interest Arbitration Agreement. This arbitration process culminated in August of 1999 when the Arbitration Board awarded an overall increase to fee-for-service remuneration of 13.4 percent, at a cost of $33.5 million, and instructed the parties to reach agreement on the specific allocation of the overall award. This allocation agreement was finalized in February 2000. The current fee-for-service agreement is effective from April 1, 1998 to March 31, 2002.

In addition to the arbitration process for fee-for-service physicians, the MMA has represented many physicians in negotiations with Manitoba Health and Regional Health Authorities where alternate funding agreements have been concluded. Physicians have also achieved alternate funding agreements through direct negotiations with Manitoba Health and the Regional Health Authorities. Arbitration is the primary form of dispute resolution mechanism in Manitoba.

A memorandum of agreement is the most formal documented agreement between Manitoba Health and the Manitoba Dentists Association (MDA). Concluded in the aftermath of the above-noted major arbitration decision, the MDA memorandum ratified 13.4 percent increases for specified oral/dental/maxillofacial surgical procedures carried out in hospital facilities only. This agreement is also effective for four years from April 1, 1998 to March 31, 2002.

Physicians are remunerated through a combination of fee-for-service payments, alternative service arrangements, independent contracts, etc. In 1999-2000, Manitoba had no capitation arrangements in place. Dentists are compensated on fee-for-service and sessional bases.

5.5 Payments to Hospitals

Division 3.1 of *The Regional Health Authorities Act* sets out the requirements for operational agreements between Regional Health Authorities and the operators of hospitals and personal care homes (defined as health corporations under the Act).

Pursuant to the provisions of this Division, Authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that provides for the health services to be provided by the health corporation, the funding to be provided by the authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request the Minister of Health to appoint a mediator to assist them in resolving outstanding

issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute and the Minister's resolution is binding on the parties.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg are to expire on March 31, 2001. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other Regional Health Authorities that continue to have hospitals operated by health corporations in their health regions (in all other regions, the hospitals are all operated by the Regional Health Authorities or the federal government). The agreements in place between the Authorities and the health corporations in question do not have expiry dates and the Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by Regional Health Authorities for the provision of hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of The *Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of The *Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health and Social Transfer (CHST) in public documents. Manitoba does not advertise or produce promotional material concerning insured or extended health services.

7.0 Extended Health Care Services

Manitoba has established community based service programs as an appropriate alternative to hospital services. These service programs are provided by Manitoba Health through the Regional Health Authorities. These services include the following:

Nursing Home Intermediate Care Services

The Personal Care Services Insurance and Administration Regulation under *The Health Services Insurance Act*, authorizes the provision of services to personal care home residents. Both proprietary and non-proprietary homes are licensed in the Province of Manitoba by Manitoba Health. Residents of personal care homes also pay a residential charge. Total Manitoba Health operating expenditures for personal care services during fiscal year 1999-2000 amounted to $311,065,400 supporting a total of 9,619 licensed set-up personal care beds. In addition, there were capital expenditures of $110,683,300[3].

[3] These expenditures are on an accrual basis.

Home Care Services

Manitoba Home Care is a province-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs.

Ambulatory Health Care Services

The *Health Services Insurance Act* includes a provision authorizing the designation of non-profit publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act. There are approximately 10 such institutions receiving funding from Manitoba Health.

Adult Residential Care Services

Residential care facilities are community based facilities that provide board and room, 24 hour on-site care and supervision, and assistance with activities to ensure that the needs of individual residents are met. These facilities are classified by size; approved homes have up to three adults; licensed facilities have occupancies of four or more adults.

Residential care facilities are required to be licensed under The *Social Services Administration Act* and Manitoba Regulation 484/88R and to meet standards established by the Residential Care Licensing Branch of the Department of Family Services and Housing. The regulations mandate the licensing of facilities for three adult disability categories (mentally ill, mentally disabled, and infirm aged).

There currently are 101 licensed and approved residential care facilities for individuals with mental illness in Manitoba, for a total of 475 bed spaces. There are also 61 mixed facilities for a total of 188 bed spaces. There are 29 licensed and approved facilities for individuals with infirmities of aging, for a total of 247 bed spaces. The majority of residential care facilities are located in Winnipeg and Brandon.

Saskatchewan

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and dental-surgical services in Saskatchewan.

Section 6.1 of the *Department of Health Act* (1978), authorizes the Minister of Health to:

- pay part or the whole of the cost of providing health services for any persons or classes of person that may be designated by the Lieutenant Governor in Council;
- pay part or the whole of the cost of providing health services in any health district or part of a health district in which social services are considered by the Minister to be required; and
- make grants or provide subsidies to any health agency as the Minister considers necessary.

Sections 8 and 9 of the *Saskatchewan Medical Care Insurance Act* (1998) provides authority for the Minister of Health to establish and administer a plan of medical care insurance for provincial residents.

The *Health Districts Act* (1993) provides authority for the Lieutenant Governor in Council to establish district health boards (section 3) and for District Health Boards to provide services (section 26). Thirty-two district health boards have been established to provide insured hospital services and a range of other health services.

Sections 5 and 11 of the *Cancer Foundation Act* (1997) provide for the establishment of a Saskatchewan Cancer Foundation and for it to coordinate a program for the diagnosis, prevention and treatment of cancer.

The mandates of the Department of Health, District Health Boards, and the Saskatchewan Cancer Foundation are outlined in the *Department of Health Act*, the *Health Districts Act* and the *Cancer Foundation Act* as described above.

1.2 Reporting Relationship

The Department of Health is directly accountable to and reports to the Minister of Health on an ongoing basis in regard to the funding and administration of funds for insured physician, surgical-dental and hospital services.

The *Health Districts Act* prescribes that a District Health Board shall, within three months after the end of each fiscal year, submit to the Minister of Health:

- a report of the District Health Board's service activities and costs;
- a detailed audited set of financial statements;
- a report on the health status of the residents of the health district; and
- a report on the effectiveness of the District Health Board's programs.

All District Health Boards are required to annually submit three-year strategic plans and annual budget plans to Saskatchewan Health.

District Health Boards also consult with staff from Saskatchewan Health on an ongoing basis about matters of concern to either the District Health Board or the Minister of Health.

The *Cancer Foundation Act* prescribes that the Cancer Foundation shall, in each fiscal year, submit a report to the Minister of Health for the immediately preceding fiscal year, about its business and a financial statement.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. That audit of Saskatchewan Health includes an audit of departmental payments to District Health Boards, the Saskatchewan Cancer Foundation and to physicians and dental surgeons for insured physician and dental-surgical services. The Provincial Auditor may also carry out audits of District Health Boards. The Provincial Auditor independently determines the scope and frequency of its audits based on accepted professional standards.

Section 36 of the *Health District Act* prescribes that the accounts of a District Health Board shall be audited at least once in every fiscal year by an independent auditor who possesses the prescribed qualification and is appointed for that purpose by the District Health Board. A detailed audited set of financial statements must be submitted annually by each District Health Board to the Minister of Health.

Section 34 of *the Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated person.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Department of Health Act* (1978) provides for the Department of Health to administer health-related acts (section 5) and outlines the powers and duties of the Minister of Health (section 6), including the powers to pay the costs of health services and to fund organizations providing health services.

The *Health Districts Act* (1993), provides for the establishment of district health boards to plan and manage the provision of health services and authority for the Minister of Health to make grants to district health boards for the purposes of the Act and to enter into agreements with district health boards respecting grants made pursuant to the Act or any other matter related to the activities or affairs of a district health board.

As of March 31, 2000, the following numbers and types of facilities were providing insured hospital services to in-patients and out-patients:

- seventy-one acute care hospitals provided in-patient and out-patient services; and
- one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one other hospital and in two special-care facilities.

The *Hospital Standards Act* and the *Hospital Standards Regulations* (1980), establish minimum standards for care and certain administrative requirements for hospitals. All hospitals must provide facilities for the provision of treatment services to in-patients and out-patients, and must have diagnostic services, x-ray and darkroom space, and a pharmacy to

facilitate adequate and accurate dispensing of drugs. At least one member of the medical staff must reside in the community in which the hospital is located. Every hospital must employ at least three full-time registered nurses, one of whom shall be the Director of Nursing, and shall ensure that there is at least one registered nurse on duty on each shift.

The *Hospital Standards Act* also provides for appointment by the Minister of one or more inspectors to inspect and report on facilities approved under the Act (section 12). The *Hospital Standards Regulations* (section 103) include the provision that every hospital may be visited at any time by the Minister, an inspector or any person authorized by the Minister to ensure compliance with the Act and these regulations."

The Department encourages and supports health districts to obtain district-wide accreditation from the Canadian Council on Health Services Accreditation (CCHSA). To date 27 health districts have been accredited by the CCHSA. The Council's accreditation process evaluates all aspects of health services delivery from a client-centred perspective. The accreditation process allows health districts to assess and compare their total organization against national quality standards so that they may achieve coordinated, responsive and appropriate programs for all residents.

A comprehensive range of insured services is provided by hospitals, including public ward accommodation; necessary nursing services, the use of operating room and case room facilities; required medical and surgical materials and appliances; x-ray, laboratory, radiological and other diagnostic procedures; radiotherapy facilities; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all drugs, biological and related preparations administered in hospital; and services rendered by individuals who receive remuneration from the hospital.

No registry or central listing is maintained of the full range of services provided by Saskatchewan hospitals (e.g., no listing is maintained of all nursing services provided, all laboratory, radiological and diagnostic procedures provided).

District health boards have the authority to change the insured hospital services they provide based on an assessment of their population health needs and available funding resources.

2.2 Insured Physician Services

Sections 8 and 9 of the *Saskatchewan Medical Care Insurance Act* (1998) provide for the Minister of Health to establish and administer a plan of medical care insurance for provincial residents.

Amendments were made in April 1999 and January 2000 to the Physician Payment Schedule of the *Saskatchewan Medical Care Insurance Payment Regulations* in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services and changes in payment levels for selected services.

Physicians can provide insured physician services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra billing for insured services.

As of March 31, 2000 there were 1,550 physicians licensed to practice in the Province and eligible to participate in the medical care insurance plan.

Physicians can opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out for all insured physician services. The physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to payment for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2000 there were no "opted out" physicians in Saskatchewan.

Insured physician services are those services that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of the *Saskatchewan Medical Care Insurance Regulations* of the *Saskatchewan Medical Care Insurance Act*.

There were approximately 3,000 different insured physician services as of March 31, 2000.

Insured physician services are added to the Medical Services Plan through a process of formal discussion with the Saskatchewan Medical Association. The Executive Director of the Medical Services and Health Registration Branch manages the process of adding a new service. When a new insured physician service is covered by the Medical Care Plan, a regulatory amendment is made to the Physician Payment Schedule.

Formal public consultations are not held about adding an insured physician service, although any member of the public may make recommendations about physician services to be added to the Medical Care Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery can provide insured surgical-dental services under the Medical Services Plan.

Ninety-seven dental specialists were providing such services as of March 31, 2000.

Dentists are able to opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to payment for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

As of March 31, 2000 there were no "opted out" dentists in Saskatchewan.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- oral surgery required in hospital as a result of trauma;
- treatment for infants with cleft palate;
- hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
- surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with the dental surgeons of the province. The Executive Director of the Medical Services and the Health Registration Branch manages the process for adding a new service. Formal public consultations are not held about

adding an insured surgical-dental service although any member of the public may recommend that surgical-dental services be added to the Medical Care Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

- in-patient and out-patient hospital services provided for reasons other than medical necessity;
- the extra cost of private and semi-private hospital accommodation not ordered by a physician;
- physiotherapy and occupational therapy services not provided by or under contract with a district health board;
- services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
- non-emergency cataract and non-emergency magnetic resonance imaging services provided outside Saskatchewan without prior written approval;
- non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- non-medically required elective physician services;
- surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
- services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with district health boards, physicians and dentists.

There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with district health boards, physicians and dentists.

Insured hospital services could be de-insured by the government if determined no longer medically necessary. The process would be based on discussions between district health boards, clinicians and officials from the Department of Health.

Insured surgical-dental services could be de-insured if determined not medically required or not required to be carried out in a hospital. The process would be based on discussion and consultation with the dental surgeons in the Province and managed by the Executive Director of the Medical Services and Health Registration Branch.

Insured physician services could be de-insured if determined not medically required. The process would be based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services and Health Registration Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services could be held if warranted.

No insured health services were de-insured in 1999-2000.

3.0 Universality

3.1 Eligibility

The *Saskatchewan Medical Care Insurance Act* (sections 2 and 12) and the *Medical Care Insurance Beneficiary and Administration Regulations* define eligibility for insured health services in Saskatchewan.

Eligibility is limited to "residents". "Resident" means a person who is legally entitled to remain in Canada who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor in Council to be a resident.

Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following their establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan provided that residency is established before the first day of the third month following their admittance to Canada.

The following categories of person are not eligible for coverage for insured health services in Saskatchewan:

- persons who are covered under Federal health programs (i.e. members of the Canadian Forces and the Royal Canadian Mounted Police; federal inmates; refugee claimants; and, Kosovo refugees who are covered under the Interim Federal Health (IFH) Program);
- visitors to the Province; and
- persons who are eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers who are covered under temporary absence provisions from their home province or territory).

However, such categories of person can become eligible for coverage as follows:

- for members of the Canadian Forces and the Royal Canadian Mounted Police – on discharge if stationed in or resident in Saskatchewan on discharge date;
- for federal inmates – on release;
- for refugee claimants – on receipt of Convention Refugee status (immigration documentation is required); and
- for Kosovar Refugees – on expiration of their coverage under the Interim Federal Health Program (immigration documentation is required).

3.2 Registration Requirements

The following registration process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident (other than a dependent child under 18 years of age) is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina/Saskatoon or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire December 2002.)

All registrations are family-based. Parents/guardians can register dependant children in their family units if they are under 18 years of age. Children 18 years and over living in the parental home or on their own must self-register.

The number of persons registered in Saskatchewan on 30 June 1999 was 1,041,256.

3.3 Other Categories of Individual

Other categories of individual also eligible for insured health service coverage include persons who are allowed to enter and remain in Canada under authority of either an Employment Authorization, Student Authorization or Minister's Permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of convention status combined with either an employment/student authorization, Minister's permit or 'permanent resident' (i.e., landing) record.

As of March 31, 2000, there were 3,750 such "temporary" residents in Saskatchewan.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency in Saskatchewan. However, where one spouse arrives in advance of the other, the eligibility for the first arriving spouse is established on the earlier of the first day of the third month following arrival of the second spouse; or, the first day of the third month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences In Canada

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of *The Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents when temporarily absent within Canada.

Continued coverage for a resident during such a period of temporary absence from Saskatchewan is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized education facility (written confirmation by Registrar of full-time student status is required annually);
- employment: up to 12 months (no documentation required); and
- vacation/travel: up to 12 months.

Section 14 of the *Saskatchewan Hospitalization Regulations* provides authority for the payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province.

Section 10 of the *Saskatchewan Medical Care Insurance Payment Regulations* provides for the payment of physician services to Saskatchewan beneficiaries temporarily residing outside the province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are the host province rates.

In 1999-2000 expenditures for insured out-of-province physician services were $13.42 million and insured out-of-province hospital services were $28.68 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of the *Medical Care Insurance Act* describe the portability of the health insurance provided to Saskatchewan residents who are temporarily absent outside Canada.

Continued coverage for students, temporary workers and vacationers/travellers during a period of temporary absence outside Canada is conditional on the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- students: for the duration of studies at a recognized education facility (written confirmation by the Registrar of full-time student status is required annually);
- employment: up to 24 months (written confirmation from the employer is required); and
- vacation/travel: up to 12 months.

Section 15 of the *Saskatchewan Hospitalization Regulations* outlines the provisions under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

In 1999-2000, $2,484,961 was paid for in-patient hospital services and $348,379 was spent on out-patient hospital services.

4.4 Prior Approval Requirement

Before the Department of Health funds the cost of an elective insured health service received by a Saskatchewan resident in another province, territory or country:

- a recommendation from a Saskatchewan physician specialist must be provided to the Department of Health advising that the service is medically necessary or required and not available in Saskatchewan or Canada respectively; and
- written prior approval must be provided by the Department of Health.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons, and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in the provision of public services (which include insured health services) on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2000, Saskatchewan had 3,217 staffed hospital beds in 71 acute care hospitals, including 2,944 acute care beds, 90 rehabilitation beds, and 183 psychiatric beds.

The Wascana Rehabilitation Hospital had 56 rehabilitation beds, 197 extended care beds and 54 Department of Veterans Affairs beds. Some additional rehabilitation beds are located in long-term care facilities.

The Department does not collect information on acute care beds used for day-care services.

Province-wide data from the Provincial Health Employer Survey shows that throughout the 1990s, there was small but steady growth in the numbers of health professionals employed in the provincial health system. In almost all cases, the number of practising health professionals in the Province increased from 1990 to 1999. There were decreases in the number of registered nurses (about 5 percent) and licensed practical nurses (about 21 percent) over that period. Saskatchewan's population has not changed substantially over the same time period, although the proportion of the population aged 75+ increased from 5.9 percent to 7.3 percent of the covered population.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 1998, the ratio of Registered Nurses to population in Saskatchewan (823/100,000) was similar to other provinces and higher than the rate for Canada as a whole (748/100,000).

In the past couple of years some hospitals have experienced shortages of nursing staff, particularly nurses with specialized training to work in areas such as operating rooms, intensive care and dialysis.

With regard to the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- magnetic resonance imaging (MRI) machines are located in Saskatoon (2) and Regina (1);
- computed tomography (CT) scanners are available in Saskatoon (three machines), Regina (three machines), Prince Albert (one machine) and Swift Current/Moose Jaw (one machine);
- renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton and Swift Current;
- cancer treatment is provided in Saskatoon and Regina where the Cancer Clinics are located;
- eighteen health districts are involved in a Community Oncology program that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon;
- approximately 70 percent of surgery services are provided in Saskatoon and Regina where there are specialized physicians and staff and the equipment to perform a full range of surgical services;
- an additional 22 percent is provided in five mid-size hospitals at Prince Albert, Moose Jaw, Yorkton, Swift Current and North Battleford, with the remaining surgery performed in smaller hospitals across the Province; and
- telehealth links have been established to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 1999-2000 to improve access to insured hospital services:

- access to Magnetic Resonance Imaging (MRI) services was improved in 1999-2000 with the provision of such service in Regina in April 1999 and the opening of a second MRI service in Saskatoon in July 1999;

- a shared CT service between the Swift Current and Moose Jaw hospitals became operational in January 2000;
- Saskatchewan Health's telehealth services continued to develop during the year;
- the installation and testing of a real-time telehealth video conferencing network connecting eight sites was completed in 1999-2000. This network, known as the Northern Telehealth Network, has sites in Saskatoon, Prince Albert, La Ronge, Pinehouse Lake, Beauval, Île-à-la-Crosse, Meadow Lake, and North Battleford. July marked the commencement of a one-year pilot project that is providing health care workers with access to a range of specialized services and continuing education;
- the installation and testing of a telehealth project linking Nipawin and Cumberland House was completed at the end of March 2000;
- network officials provided assistance to staff from the First Nations Telehealth Research Project who are establishing a telehealth site in Southend. La Ronge, Prince Albert and Saskatoon will provide specialized consulting services and continuing education to the Southend site;
- the Regina Health District began providing bone mineral density testing service for residents of southern Saskatchewan;
- renal dialysis services were brought closer to home for more patients in the northeast and the southeast parts of the Province as the Tisdale and Yorkton satellite clinics expanded their operations in June and November 1999 respectively. Planning, renovation and staff training occurred for a new satellite service in Swift Current scheduled to open in April 2000;
- the Saskatchewan Cancer Agency continued to expand the Community Oncology Program. The program was expanded in 1999-2000 and 18 health districts are now involved in this program. The program allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon; and
- Saskatchewan Health contributed $1.5 million toward the purchase of a new linear accelerator for the Saskatoon Cancer Centre in 1999-2000.

Increased funding was provided to expand the peripheral blood stem cell transplant program for cancer patients to include myeloma and leukemia patients following the program's success in the treatment of Hodgkin's Lymphoma and Non-Hodgkin's Lymphoma. The expansion of this specialized service ensures that more cancer patients can be effectively treated closer to home, reducing the financial and emotional burden of travelling long distances to receive treatment. In 1999-2000 the Stem Cell Program provided services to 42 patients.

In 1999-2000, Saskatchewan Health approved in principle or recommended for further planning projects to replace or renovate existing hospitals in Humboldt, Île-à-la Crosse, Leader, Moosomin, Melfort, Preeceville, Rosthern, Saskatoon, Spiritwood and Yorkton.

The provincial government established a $12 million wait list fund in August 1999 to address waiting list issues and reduce waiting times for insured services. The 1999-2000 fund was used to increase surgical capacity and throughput in Regina and Saskatoon where approximately 70 percent of surgery cases in Saskatchewan are performed. The funds were used by two health districts:

- to purchase additional capital equipment for surgery;
- to increase available operating room time through staff scheduling changes and moving some procedures out of operating rooms to ambulatory care;

- to fund staff recruitment, retention and training initiatives; and
- to implement a series of coordination and utilization management initiatives.

5.3 Access to Insured Physician and Dental-Surgical Services

Physicians

- as of March 31, 2000 there were 1,184 active physicians (defined as earning at least $10,000 per quarter in fee-for-service earnings) in Saskatchewan. Of these, 731 (61.7 percent) were family practitioners and 453 (38.3 percent) were specialists.

Dentists

- as Of March 31, 2000 there were approximately 370 practising dentists located in all major centres in Saskatchewan. Ninety-seven provided insured services (i.e., dental surgery).

A number of initiatives were underway in 1999-2000 to enhance access to insured physician services and reduce waiting times for physician services. These include:

- Re-entry Training Program – this program provides two grants annually to rural family physicians wishing to enter specialty training and requires a return service commitment;
- Specialist Recruitment and Retention Funding – the Regina and Saskatoon Health Districts received additional funding for the recruitment and retention of specialist physicians;
- Physician Recruitment Coordinator - A physician recruitment coordinator is assisting rural districts and physicians in recruiting physicians;
- Emergency Room Coverage and Weekend Relief Program – Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program through which $6.8 million in annual funding is used to compensate physicians providing emergency room coverage in rural areas and to assisting those communities with fewer than three physicians to gain access to other physicians to provide weekend relief;
- Rural Practice Establishment Grant Program – This program makes grants of $18,000 available to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months;
- Medical Resident Bursary Program – This program provides bursaries of $18,000 to three family medicine residents to assist them with medical educational expenses in return for a rural service commitment;
- Undergraduate Medical Student Bursary Program – This program provides an annual Grant of $18,000 to medical students that sign a return service commitment to a rural community;
- Rural Practice Enhancement Training – This program provides income replacement to in-practice rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required;
- Rural Emergency Continuing Medical Education Program – This program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program;
- Resident Weekend Relief Program – This program matches second-year Family Medicine Residents with physicians in larger rural communities who are seeking weekend relief;
- Locum Service Program – The Saskatchewan Medical Association is

funded to provide locum relief to rural physicians while they take vacation, education or other leave.

- Alternate Payments and Primary Health Services – Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services;
- Northern Medical Services Program – This program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to assist in stabilizing the supply of physicians in northern Saskatchewan;
- Rural Extended Leave Program – This program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks;
- Rural Travel Assistance Program – This program provides travel assistance to rural physicians participating in educational activities; and
- Northern Telehealth Network – This provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by the *Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the government, providing notice to commence discussion on a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare a satisfactory agreement to the parties respecting insured services;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board consisting of an appointee by either party who in turn selects a third member; and
- the Board has the authority to make a binding decision on the parties.

The current agreement expired on March 31, 2000 and the parties are in the process of negotiating a new agreement.

Section 6 of the *Saskatchewan Medical Care Insurance Payment Regulations* outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule. Amendments (by this regulation) were made to the Payment Schedule effective April 1, 1999 and January 1, 2000 to reflect the addition of new services and adjustments in payment levels for selected insured services.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services.

5.5 Payments to Hospitals

Saskatchewan adopted a population needs-based funding approach in 1994 and 1995. Through this approach, funding is allocated to each district health board on the basis of population characteristics determining service needs. Each district health board is given a global budget defined by broad service sector (e.g., institutional acute care – hospitals; institutional supportive care; home-based services), and is responsible for allocating funds

within that budget to address service needs and priorities identified through its needs assessment processes. Districts may receive additional funds for the provision of specialized hospital programs, (e.g., renal dialysis, specialized medical imaging services and specialized respiratory services) or for the provision of services to residents from other health districts.

Payments to health districts for delivering services are made pursuant *to The Health Districts Act* (1993). The legislation provides authority for the Minister of Health to make grants to district health boards for the purposes of the Act and to enter into agreements with district health boards respecting grants made pursuant to the Act or any other matter related to the activities or affairs of a district health board.

District funding, including the bulk of funding for insured hospital services, is provided through the needs-based funding approach described above.

Districts may be given additional funds for providing specialized hospital programs, such as renal dialysis, specialized medical imaging services and specialized respiratory services.

Designated funds to address surgical waiting list issues were provided to the two largest health districts in 1999-2000 on the basis of Memoranda of Understanding (MOUs) between the Department and the district. These MOUs outlined a maximum expenditure on capital equipment, with the remainder of the allocated funds to be spent on operational initiatives to increase surgical capacity and throughput. The MOUs specified expected increases in service volumes and required reporting to enable the Department to monitor compliance.

District Health Boards provide an annual report on the aggregate financial results for their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 1999-2000 Annual Budget and related budget documents, its 1999-2000 Public Accounts, and the Mid-Year Financial Report, which were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents.

7.0 Extended Health Care Services

As of March 31, 2000, the range of extended health care services provided by the provincial government included a prescription drug plan, a children's dental education program, a hearing aid program, the Saskatchewan Aids to Living Independent Living Program (which provided medical equipment and appliances to disabled persons), limited coverage for services provided by chiropractors, optometrists and chiropodists, home care services, long term care services, air and road ambulance services, community clinic and community health centre services, addiction services, public health services, mental health services and health promotion services.

Alberta

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan (the Plan) is operated on a non-profit basis and is administered by the Minister of Alberta Health and Wellness (AHW).

The Plan is enabled by the Alberta Health Care Insurance (AHCI) Act and Regulations. The AHCI Act was proclaimed in force in 1969 and provides benefits for basic health services to all Alberta residents (as defined in the Act), and extended health services to residents 65 years of age or older or who are receiving a widow's pension, and their dependants. Part 1, section 3 of the AHCI Act authorizes the operation of the Plan, section 4 describes "coverage under the plan" and section 5 describes payment of benefits and emergency services. Section 5 also prohibits extra billing and identifies "other prohibited fees."

The role and mandate of AHW is:

- to preserve, protect and improve the health of Albertans and the quality of the health system;
- to develop health policy and standards and identify resources required to sustain the health system and meet Albertans' health needs on an on-going basis;
- to ensure that health services are appropriate, well managed and accessible to all Albertans.

1.2 Reporting Relationship

The Plan is administered by the Finance and Health Plan Administration (F&HPA) Division of AHW. The ADM of F&HPA reports to the Deputy Minister of AHW who in turn reports to the Minister of Health and Wellness. The Minister is accountable to the Legislative Assembly and the Government of Alberta. In turn, the Government of Alberta is accountable to all Albertans.

The Alberta Ministry of Health and Wellness issues an Annual Report that contains the Provincial Treasurer's accountability statement, the consolidated financial statements of the province and a comparison of the actual performance results to desired results set out in the government's business plan. The Annual Report not only reports on financial data but also on results achieved on each of the Ministry's four (4) Core Business Objectives, which are:

1. set direction, policy and provincial standards,
2. allocate resources,
3. ensure delivery of quality health services,
4. measure and report on performance across the health system.

The Alberta Ministry of Health and Wellness also issues a Statistical Supplement report, annually. This report provides updated statistics relating to the Plan, primarily the number of people registered and the fee-for-service payments made to Alberta physicians and allied practitioners (oral and dental surgeons, chiropractors, optometrists and podiatrists). Statistics regarding the Extended Health Benefits (EHB) Program and the Alberta Blue Cross, Non-Group coverage offered through the Plan are also provided.

1.3 Audit of Accounts

AHW no longer maintains separate financial statements for the Plan. Audits of the expenditures relating to services under the Plan (physician services and premiums collected) are done as part of the audit of the department's accounts. The Ministry's financial statements are audited by the Office of the Auditor General of Alberta.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The regional health authorities (RHAs) have the power, authority and jurisdiction to administer the *Hospitals Act* (RSA1980 Chapter H-11) of Alberta. The regional health authorities are funded by AHW and are responsible/ accountable to the Minister. The *Hospitals Act* is the enabling legislation that provides for insured hospital services. This Act defines insured services as "the hospital services the operating costs of which will be provided for under this Part" and goes on to define Standard Ward Hospitalization and where insured services shall be furnished. These services are set out in the Hospitalization Benefits Regulation (AR244/90).

Acute Care Facilities	101
Auxiliary Hospitals (Provide sub-acute care);	6
Community Care	3
TOTAL	110

An acute care facility is defined in the "Glossary of Terms" as a hospital providing care or treatment to patients with an acute disease or health condition.

To participate in the provincial health insurance plan, facilities must meet the following conditions:

The *Hospitals Act* section 44(2(a)) states "the Minister by order may determine which hospitals offer a standard of service that qualifies as approved hospitals and declares them to be approved hospitals." The current process for an approved hospital status (acute care facilities and auxiliary hospitals) involves departmental review and ministerial approval for each stage of the process. This process includes: a needs assessment, a program and service plan, a hospital functional program, regional capital plan, identification of functional centres, facility registration and inclusion in the Ministerial Order: Schedule of Approved Hospitals.

Regional health authorities are mandated to negotiate and approve contracts for the operation of private, or voluntary operated nursing homes. Publicly owned nursing homes follow the approval process noted above for approved hospitals. As per the *Nursing Homes Act*, Part II, section 6, regional health authorities are responsible for providing the Minister of Health and Wellness with copies of all nursing home contracts.

Health facilities are provided specific facility numbers for a number of purposes; however, the main purpose is the reimbursement of physician claims.

Health facility numbers are required for the following health facilities: acute care facilities, auxiliary hospitals, mental health facilities, and nursing homes. Facility numbers are not required for: lodges which operate under the Senior Citizen's Lodge program; group homes licensed under the *Social Facilities Care Act*; or for assisted living facilities. In addition, regional health authorities do not need to apply for facility numbers for physicians' offices, or clinics. This is done by the individual physicians/clinics.

Under the *Hospitals Act*, auxiliary hospitals are designated as such by the Minister:

- Part 1(1)(b) approved hospital means a hospital designated by the Minister as an approved hospital.

The Hospitalization Benefits Regulations describes "insured services" as follows: 4(1) The following goods and services, in addition to standard ward hospitalization, are included in insured services under Part 3 of the Act:

(a) TO IN-PATIENTS:

- (i) a semi-private or private room, where a patient's medical condition makes it necessary;
- (ii) private nursing care for a patient when ordered by the attending physician and approved in accordance with hospital's by-laws;
- (iii) subject to subsection (2)(f) and (g), drugs, biological and related preparations when administered in a hospital;
- (iv) pacemakers, steel plates, pins, joint prostheses, valve implants and any other goods approved by the Minister;
- (v) transportation in Alberta, whether by ambulance or other commercial vehicle to transport a patient in the circumstances described in section 6, (i.e. transfer from one hospital to another);
- (vi) goods and services included in an approved hospital program or a specific program, but not included in subclauses (i) to (v);
- (vii) enhanced goods or services provided under section 5.2(2) (must be a medical necessity as determined by an attending physician).

(b) TO OUT-PATIENTS: any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital.

The Plan provides funding to the regional health authorities who, in turn, manage the hospitals within their regions. According to the *Hospitals Act* and Regulations, they are required to provide specifically identified "Insured Hospital Services". Services provided beyond insured hospital services would be at the discretion of the regions.

2.2 Insured Physician Services

The Medical Benefits Regulation (AR173/93) (effective in respect of benefits for services performed on or after April 1, 1993), governs the services for which benefits are payable, as well as the requirements for submission of fee-for-service claims to the Plan. This regulation sets the rates for benefits as those "set out in the Schedule of Medical Benefits prepared and published by the Department of Health and Wellness and approved by the Minister."

The AHCI Act defines "physician" as:

- with reference to medical services provided in Alberta, a person registered as a medical practitioner or as an osteopathic practitioner under the *Medical Profession Act*; and
- with reference to medical services provided in a place outside Alberta, a person lawfully entitled to practise medicine or osteopathy in that place;

The AHCI Act defines "practitioner" as:

- a chiropractor, dental mechanic, dental surgeon, optician, optometrist, physician or podiatrist or other person who provides a basic health service or an extended health service.

The *Medical Profession Act* defines "registered practitioner" as:

- a person registered in the Alberta Medical Register or who is temporarily registered under section 28.

In Alberta, only those who meet the above requirements are allowed to provide insured physician services under the Plan.

Medical Practitioners' Offices in Alberta are registered by AHW - providing the office meets AHW requirements (i.e. sees patients at the location, books appointments from the location, maintains patient files at the location, etc.), AHW will register the facility.

Prior to being registered with AHW, a practitioner must complete the appropriate AHW registration forms - a further requirement is that a copy of the practitioner's license (issued by the appropriate governing body/association - i.e. College of Physician and Surgeons of Alberta, Alberta Dental Association, etc.) to practise be provided to AHW. The College/Association is responsible for registering/monitoring their membership.

The number of practitioners participating in the Plan, as at March 31, 2000, is as follows:

Physicians	4,641
Oral Surgeons/Dentists	1,450
Chiropractors	645
Optometrists	293
Podiatrists	41
Denturists	192
Opticians	235
TOTAL	7,497

In accordance with section 5.11(1) of the AHCI Act, every physician is deemed to have opted into the Plan.

A physician may opt out of the Plan by: notifying the Minister in writing indicating the effective date of the opting out; publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practises, and posting a notice of the proposed opting out in a part of the physician's office to which patients have access, at least 180 days prior to the effective date of the opting out.

A physician who has not previously practised in Alberta may opt out of the Plan prior to commencing practise by: notifying the Minister in writing indicating the date on which the physician will commence opted-out practise, and publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician intends to practise.

A physician who has opted out of the Plan shall post a notice in a part of the physician's office to which patients have access advising patients of the physician's opted-out status, and ensure that each patient is advised in person of the physician's opted-out status before any service is provided to the patient.

A physician who has been opted out of the Plan for a continuous period of at least one-year may opt into the Plan by notifying the Minister in writing at least 30 days prior to the effective date of the opting in.

A physician who has been opted out of the Plan for a continuous period of less than one year may apply to the Minister to opt into the Plan. This application must be in a form acceptable to and contain the information required by the Minister.

As of March 31, 2000, there was one medical practitioner in the province who was opted-out of the Plan.

The Medical Benefits Regulation (AR 173/93) describes the services for which benefits are payable. These services are set out in the Schedule of Benefits prepared and published by the Department of Health and Wellness and approved by the Minister. Specifically, these services are: general medical services; general medical and surgical procedures; anaesthesia; laboratory medicine and pathology; obstetrics;

gynaecology; cardio-thoracic and vascular surgery; general surgery; orthopaedic surgery; neurosurgery; urologic surgery; otolaryngology; ophthalmology; reconstructive plastic surgery; medicine; psychiatry; paediatrics; dermatology; physical medicine and rehabilitation; emergency medicine; diagnostic radiology; therapeutic radiology; and neurology. Alberta also covers unlisted services that are deemed medically required and are not experimental or applied research.

During the period April 1, 1999 to March 31, 2000 the following services were added to the list of insured physician services covered by the Plan:

- home care advice provided to home care workers or community mental health care workers. Under specified criteria;
- home care advice provided to home care worker - advice in relation to the care and treatment of a patient receiving home care services under the Alberta home care program;
- home care advice provided to community mental health care worker - advice in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program;
- telehealth services, except for teleradiology and telepsychiatry;
- telehealth assistance service;
- midcavity vacuum extraction;
- termination of pregnancy between 13 and 20 weeks for medical or genetic reasons;
- fibula, shaft and medial malleolus;
- Screening mammography (age 40 to 49 years inclusive);
- screening mammography (age 50 to 69 years inclusive);
- screening mammography (age 70 years and over);
- diagnostic mammography, supplementary views.

Insured physician services and any subsequent changes (additions/deletions/amendments) to the Schedule of Medical Benefits are discussed between AHW and the Alberta Medical Association (AMA) through a subcommittee composed of AHW and AMA members. There is no public consultation involved in this process. Changes to the Schedule require Ministerial approval.

2.3 Insured Surgical-Dental Services

Under the AHCI Plan, Alberta insures a number of medically necessary oral surgical procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits. A dentist can perform a small number of these procedures, but the majority of the procedures can be billed to the Plan only when performed by an Oral and Maxillofacial Surgeon.

Dentists (or dental surgeons) must be registered as a member of the Alberta Dental Association or must be entitled to practise dental surgery in any place outside of Alberta. Oral and Maxillofacial Surgeons must be dental specialists in Oral and Maxillofacial Surgery, registered as a member of the Alberta Dental Association or be lawfully entitled to practise Oral and Maxillofacial Surgery in any place outside of Alberta.

In 1999-2000, there were 1,450 Oral Surgeons/Dentists participating in the Plan. However, during that period only 250 dentists and oral surgeons billed the Plan for insured oral surgery procedures.

Provisions of opting in and out of the Plan by dentists are set out in section 5.1(1) of the *Alberta Health Care Insurance Act*. Subject to this section, every dentist is deemed to have opted into the Plan. A dentist may opt out of the

Plan by notifying the Minister in writing indicating the effective date of the opting out; publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the dentist practises, and posting a notice of the proposed opting out in a part of the dentist's office to which patients have access at least 30 days prior to the effective date of the opting out.

A dentist who has not previously practised in Alberta may opt out of the Plan prior to commencing practise by: notifying the Minister in writing indicating the date on which the dentist will commence opted out practise, and publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the dentist intends to practise.

A dentist who has opted out of the Plan shall: post a notice in a part of the dentist's office to which patients have access advising patients of the dentist's opted out status, and ensure that each patient is advised in person of the dentist's opted out status before any service is provided to the patient.

A dentist who has opted out of the Plan may opt into the Plan by notifying the Minister in writing at least 30 days prior to the effective date of the opting in.

As of March 31, 2000, there are no opted-out dentists or oral surgeons in Alberta.

The following procedures are insured under the Alberta Health Care Insurance Plan and are listed in the Oral and Facial Surgery Benefits Regulation. [NOTE: Decisions such as to (a) whether the procedure is medically necessary, and (b) where it should be performed, are left to the surgeon and depend on the medical needs of the patient]: diagnostic interview and evaluation or consultation; arthroscopy temporo-mandibular joint; injection or infusion of other therapeutic or prophylactic substance; cranioplasty; operations on cranial peripheral nerves; submucous resection of nasal septum; reduction of nasal fracture; intransal antrotomy; repair and plastic operation of nasal sinus; excision of dental lesion of jaw; other orthodontic operation; repair and plastic operations on tongue; other operations on tongue; incision of salivary gland or duct; excision of lesion of salivary gland; other operations on salivary gland or duct; drainage of face or floor of mouth; incision of palate; excision of lesion or tissue of palate; plastic repair of mouth (internal); palatoplasty; invasive diagnostic procedures on oral cavity; other operations on mouth and face; plastic operation on pharynx; control of hemorrhage, not otherwise specified; reduction of facial fractures; incision of facial bone without division; temporomandibular arthroplasty; other facial bone repair and osteoplasty; invasive diagnostic procedures on facial bones; other operations on facial bones and joints; sequestrectomy; synovectomy; repair and plastic operations on joint structures; incision of muscle, tendon, fiscia and bursa; relaxation of scar or contracture of skin; flap or pedicle graft; oral and burn appliances.

Any addition of new surgical-dental items to the list of insured services is managed by the Claims Branch in the Finance and Health Plan Administration Division of AHW. Changes to the Schedule require Ministerial approval. All changes (both addition or deletion of items) are done through extensive consultation with the Alberta Dental Association (ADA) and the Oral Maxillofacial surgery section of the ADA, and are supported by impact assessment studies. Depending on the changes, the regional health authorities may also be consulted.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

According to section 21 of the Alberta Health Care Insurance Regulations, the following services are not basic health services or extended health services and therefore are not considered insured services:

- medico-legal services including: examinations performed at the request of third parties in connection with legal proceedings; giving of evidence by a practitioner in legal proceedings, or preparation of reports or other documents relating to the results of a practitioner's examination for use in legal proceedings or otherwise and whether requested by the patient or by a third party;
- advice by telephone or any other means of telecommunication and toll charges or other charges for telephone calls or telecommunication services except as provided for in the Schedule of Medical Benefits under the Medical Benefits Regulation or as otherwise approved by the Minister;
- unless otherwise directed by the Minister, transportation services including ambulance services or transportation of a patient to a hospital or to a practitioner elsewhere, or transportation of a practitioner to a hospital or to a patient elsewhere, whether the costs of those services are by way of charges for distance or charges for travelling time;
- examinations required for the use of third parties, except as otherwise directed by the Minister;
- services that a resident is eligible to receive under a statute of any other province, the *Hospitals Act*, any statute relating to workers' compensation or under any statute of the Parliament of Canada including: the *Aeronautics Act*, the *Civilian War Pensions and Allowances Act*, the *Corrections and Conditional Release Act* (Canada), the *Government Employees Compensation Act*, the *Merchant Seamen Compensation Act*, the *National Defence Act*, repealed AR 52/96 s2, the *Pension Act*, the *Royal Canadian Mounted Police Act*, and the *Veterans Rehabilitation Act*;
- services not provided by or under the supervision of a practitioner;
- services for which the patient would not be liable to pay in the absence of benefits for health services;
- services that the Minister, on review of the evidence, determines not to be health services because the services are not required, or are experimental or applied research;
- services in connection with group immunizations against a disease or services in connection with group examinations by a practitioner except in cases where the Minister has given prior approval;
- services provided by a practitioner to his children, siblings, parents and spouse, except where the Minister rules otherwise;
- laboratory and X-ray services performed in a facility not approved by the Minister; services provided outside Canada that are available inside Canada, (other than services provided in the case of an emergency) without the prior approval of the Minister unless the Minister directs otherwise; services provided outside Canada that are not available inside Canada unless approved by the Out-of-Country Health Services Committee;
- except as provided in the Schedule of Medical Benefits under the Medical Benefits Regulation, drugs, plaster, surgical appliances or special bandages.

The following services are not insured benefits under the Schedule of Oral Surgery Benefits:

- services for cosmetic purposes;

- an initial examination and consultation for services not related to an insured service;
- radiographs taken by an oral and maxillofacial or dental surgeon;
- all dental laboratory procedures performed in association with surgery, including mounted unmounted casts, split cast mountings, or other prosthetic devices;
- pre and post surgical orthodontics;
- general anaesthesia or intravenous sedation administered by an oral and maxillofacial or dental surgeon;
- any drugs or medication;
- any treatment or procedure performed on the teeth (with the exception of extraction of teeth in a line of fracture);
- consultations for transfer of care.

As well, services paid by Workers' Compensation Board, third-party requests, and enhanced medical goods and services are not covered.

Section 5 (Responsibilities of Authority) of the *Regional Health Authorities Act* states as follows: Subject to this Act and the regulations, a regional health authority: shall (i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury, (ii) assess on an ongoing basis the health needs of the health region (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly, (iv) ensure that reasonable access to quality health services is provided in and through the health region, and (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Regional health authorities are responsible for ensuring that decisions related to access to insured services are based on medical need. In addition, AHW has eliminated any incentive for hospitals to give priority to WCB cases by not allowing higher rate for Workers' Compensation Board (WCB) day surgeries.

In accordance with section 31.1(1) of the Alberta Health Care Insurance (AHCI) Regulations, no person may charge a fee (a) the payment of which is a condition of receiving an insured service provided by a physician who is enrolled in the Plan or a dental surgeon who is opted into the Plan, and (b) that is in addition to the benefit payable by the Minister for the insured service.

Insured physician services and any subsequent changes in the form of deletions or amendments to the Schedule of Medical Benefits are discussed between AHW and the AMA through a subcommittee composed of AHW and AMA members. Changes to the schedule require Ministerial approval.

3.0 Universality

3.1 Eligibility

Sections 3(1) and 4(3) of the *Alberta Health Care Insurance (AHCI) Act* and sections 4(1), 4(2), 4.1 and 4.2 of the AHCI Regulations define eligibility to the Plan.

All residents of Alberta are eligible to receive health insurance coverage on uniform terms and conditions. The term "resident" is defined as a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in Alberta and any other person deemed by the regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

Persons from outside Canada who move to Alberta to establish permanent residence are eligible for coverage if they are landed

immigrants, returning landed immigrants or returning Canadian citizens. All new landed immigrants must provide a copy of their Record of Landing.

Persons moving permanently to Alberta from another country are eligible for coverage on their date of arrival provided all Canada Entry Documents are in order and they register within three months of arrival. Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

Residents who are not eligible for coverage under the Plan are:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank;
- persons serving a term in a federal penitentiary;
- however, their family members are eligible for coverage; and
- a resident who has not completed the waiting period prescribed in the regulations.

The families of members of the Canadian Forces, ranked members of the Royal Canadian Mounted Police, and persons serving a term in a federal penitentiary, are eligible for coverage.

Alberta residents who cease to be a member of the Canadian Forces or the RCMP and are released in Alberta are eligible for coverage on the day following release if application is made within three months of release. Alberta residents who complete a term of imprisonment in a federal penitentiary and are released in Alberta are eligible for coverage on the day of release provided they apply within three months of release.

3.2 Registration Requirements

All new Alberta residents, except those specifically exempt, are required to register themselves and their eligible dependants with the Plan by completing an application. New residents to Alberta should apply for coverage within three months of arrival. If the application is not received within the required time, the effective date is determined at the time of registration. Following registration, the account holder and dependants, if any, are each given a personal health number and card, which is used to obtain health services.

For billing purposes, family members are covered on the same account. Families are also registered together to ensure that benefits (e.g., Extended Health Benefits, Non-Group Blue Cross) can be provided to all members of the family unit.

In most cases, dependants are defined as a husband or wife and children under 21 years of age who are single and wholly dependent on the parent(s). Dependants can also be:

- adopted children, foster children and ward for whom the resident is entitled to claim income tax deductions;
- single children over 21 who are wholly dependant because of physical or mental disabilities;
- single children under 25 who are full-time students at an accredited educational institution; separated or common-law spouses (who may also choose to pay premiums independently).

As of March 31, 2000, the estimated number of residents registered with the Plan was 2,951,055 (1,399,628 accounts).

Residents who object to the Plan may opt out. Residents can opt out at the beginning of each benefit period. A benefit period begins July 1st of one year and ends June 30th of the following year. A Declaration of Election to Opt Out must

be completed and filed with the Plan by June 30th of each year. Also, premiums must be fully paid to June 30th of the current year. New account holders can opt out at the time of registration or reinstatement. The opt out period begins the day coverage would have become effective. To remain opted out, a Declaration of Election to Opt Out must be completed and filed with the Plan by June 20th of each year.

As of March 31, 2000, the estimated number of people opted out of the Plan was 246 (112 accounts).

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Students or Employment Authorizations, and Minister's permits.

In each of these cases, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. The general rule is that a person must have permission to stay in Canada for at least 12 months and intend to spend that time in Alberta to be eligible.

Refugee claimants who entered Canada before January 1, 1989 and who intend to reside in Alberta for 12 months are also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989 are not eligible for coverage until they are deemed to be convention refugees.

The following figures are as of June 7, 2000:

Minister's Permit	137
Student Authorization	4,128
Visitor's Record	2,589
Employment Authorization	4,483

3.4 Premiums

All residents of Alberta (except dependants and those excluded from registering) are required to pay premiums. The current monthly premium rates are $34 for single coverage and $68 for family Coverage (two or more people).

There are two programs available to assist low income, non-senior, Albertans with the cost of their premiums; the Premium Subsidy and the Waiver of Premiums Program. Seniors are required to pay premiums at the same rate as non-seniors. Seniors' eligibility for premium assistance is determined through the Alberta Seniors Benefit Program.

Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to pay premiums.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences In Canada

Section 5(3) of the AHCI Act and section 1(2) of the AHCI Regulation defines portability of health insurance during temporary absences, in Canada:

Residents leaving Alberta temporarily for a vacation, visit, business engagement or employment are eligible for a maximum of 12 consecutive months coverage from their date of departure. Full-time students at an accredited educational institute are eligible for coverage for the duration of their studies. Student status

must be verified each year. Residents absent for educational leave from employment for advanced training or sabbatical leave are eligible for a maximum of 24 consecutive months coverage from their date of departure. A letter from the employer confirming their training and length of absence is required for coverage to extend beyond the first 12 months. Residents absent for missionary work for an approved registered organization are eligible for a maximum of 48 consecutive months' coverage from their date of departure. A letter from the religious organization confirming their destination and length of absence is required for coverage to extend beyond the first 12 months.

Changes to the *Alberta Health Care Insurance Act* Regulation on temporary absences have recently been implemented by Alberta Health and Wellness. These changes will allow more flexibility in considering requests for periods of continued coverage for temporary absences not currently addressed in the guidelines. Particulars of these changes will appear in the 2000-2001 *Canada Health Act Annual Report*.

Alberta participates in the Hospital Reciprocal Agreement with the provinces and territories, which allows for the processing of hospital costs provided to Albertans and non-Albertans by the host province. Claims are paid at the standard ward rate for in-patient insured services approved by each provincial/territorial jurisdiction and at the out-patient rates for insured services approved by the Co-ordinating Committee on Reciprocal Billing. Exchange of claims data between each jurisdiction takes place on a monthly basis.

Alberta also participates in the Medical Reciprocal Billing Agreement with the provinces and territories (except Quebec), The Agreement allows for the processing of medical costs provided to Albertans and non-Albertans by the host province. Claims are paid in accordance with the rates, rules and regulations of the host province's physician's fee schedule for insured medical services. Exchange of claims data between the provincial/territorial jurisdictions takes place on a monthly basis.

Some services excluded from this billing process, such as abortions, must be billed directly by the physician to the patient's home province for payment consideration.

The Capital Health Authority has also entered into an agreement with the Northwest Territories that allows for Northwest Territories' patients to be treated within the region's hospitals and be paid at an agreed to in-patient rate. The billing process for these claims is similar to the in-patient hospital reciprocal billing arrangement between the provinces and territories. Services that are excluded from reciprocal billing are also excluded from this bilateral agreement with Northwest Territories.

Payment for insured hospital and medical services provided to eligible Albertans elsewhere in Canada is at the rate approved by the hospital insurance plan of the province or territory in which the goods or services are provided, unless the Minister has entered into an agreement with the government of a province or territory to apportion the costs in a different manner.

Payments for insured medical services provided to eligible Albertans elsewhere in Canada are at the host provincial or territorial rates, including Quebec.

Prior approval is required for the treatment of alcohol and substance abuse, eating disorders and similar addictive/behavioural disorders, whether the treatment is out-of-province or out-of-country.

In 1999-2000, the total amount paid for emergency in-patient and out-patient hospital services provided out-of-province (within Canada) was $ 20,553,432.

4.3 Coverage During Temporary Absences Outside Canada

Section 5(3) of the AHCI Act and section (2) of the AHCI Regulations defines portability of health insurance during temporary absences, outside Canada (please see details under previous section).

Residents are entitled to the same periods of temporary absence coverage whether they remain in Canada or travel outside Canada (please see details in previous section).

Hospital benefits are payable only when services are provided in acute care facilities that provide standard services such as Intensive Care Units. or emergency ward or auxiliary hospitals that provide standard acute care services to long-term or chronically ill patients. If services are not insured in the province, they are not insured when provided outside the country. The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day (not including day of discharge). The maximum hospital out-patient per visit rate is $50 (Canadian). Some specialists' out-patient services, such as CAT scans, are paid at higher rates.

Benefits for out-of-country practitioner services are payable according to the fee charged or the Alberta rate, whichever is the lesser.

Full coverage of treatment costs outside Canada may be provided under the following two programs: 1. the Out-of-Country Health Services (OOCHS) Program which may apply where the required service is not available in Canada, and 2. the Emergency Financial Assistance Program, which may apply where the treatment expense could not have been guarded against.

4.4 Prior Approval Requirement

Prior approval is required for elective services outside Alberta for treatment of alcohol and substance abuse, eating disorders and similar addictive/behavioural disorders. This applies whether the treatment is received out-of-province or out-of-country.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services is available to provincial residents on uniform terms and conditions without barriers.

Inability to pay premiums does not prevent residents of Alberta from receiving insured health services, registrations are not cancelled because of non-payment of accounts. Also, Alberta has 2 programs in place to assist low-income persons with payment of premiums - they are: 1. The Premium Subsidy Program, and 2. The Waiver of Premiums Program.

Since 1986, "extra billing" by physicians and "user charges" to patients for insured services are prohibited.

Alberta's Good Faith policy allows practitioners to submit claims for services provided to patients who are unable to provide an Alberta health care number at the time of service. This can be done one time only per patient and the practitioner must first satisfy him/herself that the patient is an Alberta resident.

5.2 Access to Insured Hospital Services

Since 1994, the delivery of hospital services is the responsibility of the regional health authorities.

In March of 1999, the government announced a three-year plan outlining increases in funding to the provincial health system.

Under this plan, Alberta's health system received an additional $386 million (8.7 percent) (plus a total increase of $935 million (21 percent) over the next three years). This is close to a billion-dollar boost for health over the three years from 1999-2000 to 2001-2002.

The increased funding was focused so that regional health authorities hire an additional 1,000 front-line staff. It also addressed long waiting times for some procedures by providing for significant increases in the number of key, life-saving surgeries, including cardiovascular surgery, angioplasties, craniotomies and major organ transplants, as well as increasing hip and knee replacements. The new funding also provided increases for mental health and cancer services; increased access to long term care; and increased support for the development of a province-wide information technology system.

Regional health authorities received total funding increases of $261 million in 1999-2000. This amount provides a 3 percent minimum increase for each RHA and recognizes projected population growth for the coming year, a $10 million Health Innovation Fund to encourage innovation and improvement in the management and delivery of health services, and an increase of $24 million (11 percent) for cancer and mental health services, including an additional $5 million to better integrate community mental health services in the province.

Other funding highlights include:

- a $3 million palliative care drug program. The Palliative Care Drug Program offers premium-free coverage with no waiting period and is open to any Albertan who has been diagnosed as being palliative and is eligible to receive benefits through the Alberta Health Care Insurance Plan; and
- an increase of $24 million (10.8 percent) for the Blue Cross Benefit Program to reflect the increasing cost of new drugs and increased use of drugs.

MRI service in the province was also increased in 1999-2000:

- Chinook Health Region launched a new MRI service at the Lethbridge Regional Hospital in July of 1999;
- a new state-of-the-art MRI unit opened in 1999 at the Royal Alexandra Hospital in Edmonton;
- an existing MRI unit was replaced with a newer unit at the University of Alberta Hospital.

By July of 1999, Alberta had increased the number of MRI units in the province by more than 70 percent since 1995-1996.

On November 18, 1999, $265.8 million in funding was allocated to add new long-term care beds and replace or renovate existing health facilities in the province.

On November 19, 1999, a $216 million one-time allocation was made to all health authorities in the province. Regional health authorities with debt were required to use the funds first to eliminate that debt. Beyond debt, they may use the funding for equipment; one-time expenditures on innovative projects which promote the efficient and effective use of resources; or they may set aside the funds for future use.

On February 29, 2000, $10 million in funding was awarded to 16 of Alberta's 17 regional health authorities, the Alberta Cancer Board and the Alberta Mental Health Board to address priority medical equipment needs.

5.3 Access to Insured Physician and Dental-Surgical Services

In 1999-2000, new funding initiatives for physician services included:

- an increase of $49.9 million (5.8 percent) for physician services - including education;
- an increase of $3.2 million (32 percent) to the Rural Physicians Action Plan to continue to enhance efforts to recruit and retain physicians for rural Alberta;
- $1.9 million increase over the next two years for post-graduate medical education training – total positions funded by AHW for post-graduate medical education will move from 716 to 756 per year. There will be new entry-level positions, re-entry training spots for practising physicians and new sub-speciality positions in such areas as geriatric medicine and radiation oncology;
- eight entry-level seats will be reserved for international medical graduates who are Alberta residents;
- an additional $15 million will be provided to the Medical Services Budget for the 1999-2000 and upcoming budget year to help pay for the approximately 170 new full-time equivalent physicians who came to Alberta this fiscal year, in addition to those anticipated for the coming year. This funding is in addition to the already approved $948 million for the 1999-2000 Medical Services Budget.

5.4 Physician Compensation

In 1998, AHW and the AMA signed a five-year master agreement governing the provisions of physician services to Albertans. This agreement covered the years 1998-1999 to 2003-2004. All prior agreements were terminated and superseded by this new agreement. The agreement covers three years of financial arrangements, 1998-1999 to 2001-2002, under which AHW provides the AMA with a negotiated hard cap to pay for the fee-for-service billings by physicians and a number of physician benefit programs. The agreement was ratified by a majority of the AMA membership.

Most physicians are paid on a fee-for-service basis, for providing insured services. The only exception to this is the Alternate Payment Plans (APP) in place in Alberta. In these instances, the Minister has entered into agreements with the regions/facilities/practitioners whereby insured services are provided to residents of a specific location or specific need in accordance with one of four funding models (described below). Funding for these APPs is provided mainly through the Medical Services Budget and is not reflected in the Annex of the Report.

- CAPITATION: Typically used for primary care, sees physician payment based on a predetermined funding amount per person, per period of time (usually one year). The Capitation rate is set by taking a number of factors into account, including age, gender and the pre-set range, or basket of services covered;
- SESSIONAL: Based largely on the amount of time a physician would spend delivering medical services to a defined group (e.g., daily, weekly, monthly, etc.). Sessional funding arrangements must be part of a regional health authority program, and must provide and adhere to a set service delivery model;

- BLOCK FUNDING: Based on all physicians in a given area agreeing to provide all their medical services for a specific period of time at specific sites.
- CONTRACTUAL: Allows for physicians to be funded based on a specific category of services over a set period of time for a pre-determined volume of services.

5.5 Payments to Hospitals

The *Regional Health Authorities Act* (RHA) sets out the requirements for the establishment and governance of health regions in Alberta.

In accordance with section 8 of the RHA Act, the authority must submit a proposal for a health plan for the region to the Minister. This proposal shall contain a statement as to how the authority proposes to carry out its responsibilities and measure its performance in the carrying out of those responsibilities, as well as information respecting health services to be provided and the anticipated cost of providing those services.

In accordance with these agreements, the Regions are funded by the AHCIP using a population based funding formula and methodologies for consistent costing of regional health authority services. In 1998-1999 $2.9 billion in block funding was provided to the regional health authorities. The regional health authorities are responsible for allocating these resources among the services they deliver to Albertans. These services include hospital services.

The Health Authorities are accountable and report to the Minister of Health and Wellness. The Minister has the authority to request records, reports and returns from the regions, as well as an annual report on its activities. The annual reports are subsequently presented to the Legislative Assembly by the Minister and are included in the *Alberta Ministry of Health and Wellness Annual Report*.

6.0 Recognition Given to Federal Transfers

Monies received under the Canada Health and Social Transfer by the Province of Alberta are listed in the Income Statement in the province's three-year business plan and are also shown on a schedule of revenues in the Department's financial statements. They are also listed in the Ministry's Annual Report and Statistical Supplement.

7.0 Extended Health Care Services

Alberta's Long Term Care Centres provide room and board and a range of care services, from personal care with nursing supervision to skilled medical and therapeutic services. In most instances, these auxiliary hospitals and nursing homes are referred to as Continuing Care Centres and meet the needs of residents with similar care requirements. Funding for Continuing Care Centres has been transferred to the 17 RHAs. RHAs either operate the Continuing Care Centres or sign contracts with voluntary or private operators to deliver these services.

The Home Care Program is also delivered through the RHAs and provides a variety of professional health and support services to assist individuals of all ages to return or remain at home. All Home Care Programs provide assessment, case co-ordination, and nursing and support services such as personal care and home support. Other services may include occupational, physical and respiratory therapy, speech-language pathology, social work and nutrition services.

Admission to the continuing care system, which includes Home Care, Continuing Care and Community Care Centres and Adult Day Programs, is based on a functional assessment of the individual's need, using the Alberta Assessment and Placement Instrument (AAPI). The Single Point of Entry (SPE) process was developed to provide a single point of access to individuals seeking facility or community-based long-term care. Its purpose is to ensure that all possible community options are explored before facility-based care is considered. Home Care staff conduct assessments, identify needs with clients and their families, and recommend health and support services that best suit these needs.

AHW also administers the Alberta Aids to Daily Living (AADL) Program. The purpose of AADL is to enhance the independence of clients living at home who have a chronic or terminal illness or disability, by assisting them with the provision of Program-approved medical equipment and supplies. Clients are assessed for eligibility by authorizers working in community care, continuing care or acute care settings.

Mental health services delivered by the Provincial Mental Health Advisory Board (PMHAB) include community clinics, two mental health hospitals, two care centres, 67 community mental health clinics and 3 satellite offices, as well as various non-profit community agencies. Services provided by the clinics include assessment and treatment of individuals and families and consultation to physicians, health facilities, health units, schools and community agencies. Two mental health hospitals provide assessment, treatment and rehabilitation for adults with mental illnesses, including mentally ill offenders, and for adults with brain injuries. Two residential care centres provide long-term rehabilitation programs for people with severe mental illness. The PMHAB also provides the governance function for four mental health provincial programs: Forensic Psychiatry, Geriatric Psychiatry, Adult Tertiary Care and Brain Injury.

Other mental health services provided by RHAs include specialized psychiatric services located in 17 hospitals throughout the province. Family physicians, Home Care Programs and Continuing Care Centres also provide services to people with mental illness.

In 1999-2000, the Ministry provided $96.5 million to the Alberta Cancer Board (ACB) to support its operating and various research programs. As well, an additional $2.5 million was provided to the ACB for research from the Department of Innovation and Science.

British Columbia

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, by the Regional Programs Division of the Ministry of Health and the Ministry Responsible for Seniors. This program is responsible to the provincial government for the ongoing funding of the Province's public hospitals, delivered via funding and transfer agreements with regionalized health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act*, and the *Hospital District Act*. This entails expenditures and commitment controls for the operation of hospitals (amalgamated and non-amalgamated) and designated facility societies, provision of funds for hospital construction and equipment, and payment of out-of-province hospital costs for qualified British Columbia residents.

The Medical Services Plan (MSP) of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health and facilitates, in the manner provided for under the *Medicare Protection Act* (1996), reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is carried out by the employees of the Medical Services Plan program of the Ministry of Health.

The Commission's powers include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, negotiating agreements with practitioners and their associations, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing or investigating practitioners' billings and patterns of practice concerning claims submitted, and hearing appeals from practitioners and beneficiaries.

1.2 Reporting Relationship

Regional health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health in accordance with provincial policy. Non-amalgamated hospitals are required to report health information data to the Ministry of Health in accordance with provincial policy, and to their regional health authority as requested by the health authority. The Regional Programs Division reports to government through the Ministry of Health Annual Report.

The Medical Services Commission reports annually to the Minister in a separate Financial Statement. The Statement is included in the Ministry of Health Annual Report to government. The 1998-1999 Annual Report was submitted to the Lieutenant Governor of British Columbia on May 16, 2000.

1.3 Audit of Accounts

The Regional Programs Division and the Medical Services Commission are subject to audit of their account and financial transactions through three types of auditors. Internally, the Ministry of Health Financial Policy and Monitoring Branch reviews Ministry operations.

The Office of the Comptroller General's Internal Audit Branch is the provincial government's internal auditor and the Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly.

The Office of the Auditor General initiates its own audits and determines their scope. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determine when the Ministry has complied with the findings. The Comptroller General determines the scope of their internal audits and times the audits in consultation with the audit committee of the Ministry of Health. The Ministry's Senior Financial Officer determines the scope and timing of reviews conducted by the Financial Policy and Monitoring Branch.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided in facilities specified in the *Hospital Insurance Act*. In 1999-2000 there were 94 acute care hospitals, 3 rehabilitation hospitals, 17 free-standing extended care hospitals and 25 diagnostic and treatment and other health centres.

Insured in-patient services provided by hospitals are accommodation and meals at the standard or public ward level; necessary nursing services; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister; clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the *Hospital Insurance Act;* routine surgical supplies; use of operating room and case room facilities; anaesthetic equipment and supplies; use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and other services approved by the Minister that are rendered by persons who receive remuneration from the hospital. Qualified persons not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Hospital out-patient benefits include out-patient renal dialysis treatments in designated hospitals or other approved facilities; diabetic day-care services in designated hospitals; out-patient dietetic counselling services at hospitals with qualified staff dieticians; psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day-care services; cancer therapy and cytology services; out-patient psoriasis treatment; abortion services; and MRI services.

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

Ambulance services are provided within the Province by the British Columbia Ministry of Health through the Emergency Health Services Commission, with a nominal charge to the patient.

In 1999-2000, no new services were added to the list of insured hospital services covered by the *Hospital Insurance Act.*

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act* (1996). The Medical Services Plan provides for all medically required services of medical practitioners. The broad range of services covered includes consultations; complete

examinations; home visits; major and minor surgery; obstetric services; surgical assistance; anaesthesia; diagnostic/therapeutic procedures; special and miscellaneous services; other office procedures; and other hospital procedures performed by a physician.

To practise in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the Medical Services Plan. There were 7,545 physicians enrolled and billing fee-for-service as of March 2000 in the fiscal year 1999-2000 In addition, some physicians practice solely on salary or receive sessional payments under alternative payment mechanisms. Most physicians paid by alternative mechanisms also practice under fee-for-service basis.

A physician can choose not to enrol or to de-enrol with the Medical Services Commission. Enrolled physicians can cancel their enrollments by giving 30 days' written notice to the Commission. Services provided by un-enrolled physicians are not insured benefits and patients are responsible for the full cost of the service. Only one previously enrolled physician had de-enrolled as of March 31, 2000.

Enrolled physicians may elect to be paid directly by beneficiaries by giving written notice to the Medical Services Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries can apply to the Medical Services Plan for reimbursement of the fee for insured services rendered. Only eight physicians had opted out as of March 31, 2000.

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental/oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the MSP, who is providing one or more of the limited insured dental -surgical services in a hospital, may provide an insured dental-surgical service. There were 160 dental surgeons and 3 oral surgeons enrolled in 1999-2000. None have de-enrolled and none have opted out of the MSP.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patient, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are diagnostic out-patient services not associated with emergency services; the services of medical personnel not employed by the hospital; treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible; services solely for the alteration of appearance; and reversal of sterilization procedures. Uninsured hospital services also include preferred accommodation at the patient's request; televisions, telephones and private nursing services; preferred medical/surgical supplies; dental care that could be provided in a dental office including prosthetic and orthodontic services; and preferred services provided to patients of extended care units and hospitals.

For the Medical Services Plan, services not insured are those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any third-party request for a medical examination or certificate; oral surgery rendered in a dentist's office; acupuncture; group immunizations; telephone advice; reversal of sterilization procedures; *in vitro* fertilization; medico-legal services; cosmetic services; and preventive medical counselling, for example, smoking withdrawal programs.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services. The status of the patient as a beneficiary of a third party payer should not affect this determination. In this way, third parties are not given priority access to insured services over insured persons.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the *Medicare Protection Act* prohibits persons from charging a beneficiary *"for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit."* The Ministry of Health responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are insured as benefits under the Medical Services Plan and has the authority to de-list insured services. Proposals to de-insure services may be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee. In 1999-2000, the Commission de-insured patient or third-party requested second opinions under the *Mental Health Act*.

3.0 Universality

3.1 Eligibility

For insured hospital services the eligibility terms and requirements are set out in the *Hospital Insurance Act* sections 2, 3, 4, 6 and 7 and the *Hospital Insurance Act* Regulations, sections 1, 3, 4 and 9.3. Provincial policy on eligibility for hospital services is set out in chapter 2 of the Ministry's *Acute Care Policy Manual*.

The *Medicare Protection Act* defines the eligibility and enrolment of beneficiaries of insured physician services. The Act's regulations (Medical and Health Care Services Regulations) detail residency requirements in Part 2. A person must be a resident of British Columbia in order to qualify for provincial health care benefits. The *Medicare Protection Act* defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding members of the Canadian Forces, the Royal Canadian Mounted Police and inmates of federal penitentiaries are entitled to hospital and medical care insurance coverage.

The Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia there is a waiting period that consists of the balance of the month the person establishes residency in British Columbia plus two months.

3.2 Registration Requirements

As of April 1, 1998, residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those eligible for coverage are required to enrol. Once enrolled, there is no expiration date of coverage. New residents are advised to make application immediately upon arrival in the Province. Each person who enrols with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrolment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries can cover their dependents, provided the dependents are residents of the Province. Dependents include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward under the age of 19 years supported by the beneficiary, or a child under the age of 25 years and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2000 was 3.8 million. Enrolment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2000, 96 people had opted out.

3.3 Other Categories of Individual

Refugee "claimants" are not eligible for insured health services. Individuals who are approved for refugee status and who are, therefore, entitled to reside in Canada on a permanent basis are eligible for insured health services. The effective date of benefits depends on whether refugee status was determined in Canada or abroad.

Individuals who would not normally qualify for landed immigrant status due to medical inadmissibility and who have their cases assessed for compassionate or humanitarian consideration may be granted Minister's Permits. Persons granted Minister's Permits under those conditions may enrol in the Medical Services Plan for insured health services.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for the Medical Services Plan are $36 for one person, $64 for a family of two, and $72 for a family of three or more. Residents of limited means may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident status (landed immigrant).

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19.The client rate represents the cost of accommodation and meals. Clients pay according to their net income. As of March 31, 2000, the rates ranged from $25.60 to $50 per day. About 70 percent of clients pay the lower rates.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a resident.

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions with respect to insured physician services for persons with temporary absences from British Columbia but still residing within Canada. Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province to bring about a high degree of liaison and cooperation between the provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province to the other without ceasing to be entitled to benefits.

Individuals who leave the Province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Effective January 1, 1998, approval is limited to once in five years for such absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their homes in British Columbia. Students attending a recognized school in another province on a full-time basis are entitled to coverage for the duration of their studies.

According to interprovincial and interterritorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered.

For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

The Financial Administration section of the *Acute Care Policy Manual* sets out the specific details of the current interprovincial reciprocal billing agreement for insured hospital services. Each provincial hospital insurance plan will process hospital in-patient and out-patient accounts on behalf of the residents of the other provinces and territories, with the exception of Quebec, which is not a signatory to the agreement. The agreement covers benefits rendered within provincial and territorial boundaries and makes provision for periodic settling of accounts between provinces and territories.

4.3 Coverage During Temporary Absences Outside Canada

The *Hospital Insurance Act* Regulations and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full time basis retains eligibility during the absence for study until the last day of the month in which the person ceased full time attendance at that educational institution, or if studying outside Canada, the last day of the 60th month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed to be a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence if this person obtains prior approval from the Medical Services Commission, does not establish residency outside British Columbia, and has not been granted approval for a similar absence during the preceding 60 months.

With prior authorization, coverage is provided for hospital services not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Renal dialysis day care is available at the interprovincial and interterritorial Canadian rate. In all other cases, including emergency or sudden illness during temporary absences from the Province, in-patient hospital care is paid up to $75 Canadian per day for adults and children, and $41 Canadian per day for newborns.

Out-of-country medical services are covered for emergency or sudden illness during temporary absences from the Province. These are paid up to the same fee payable for that service, had it been performed in British Columbia. Cases pre-authorized because of extenuating circumstances, however, are paid at the rate applicable where the service is rendered. With prior authorization, payment for non-emergency medical services outside the country may be made at usual and customary rates, when the appropriate treatment is not available in the Province or elsewhere in Canada.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the inter-provincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of the Regional Programs Division (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require prior approval from the Commission.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes there is reasonable access to hospital and medical care services. Beneficiaries as defined in the *Medicare Protection Act* and the Ministry's Acute Care Manual are eligible for all insured hospital and medical care as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act,* section 17, prohibits extra billing for medical services provided by enrolled physicians.

5.2 Access to Insured Hospital Services

In 1999-2000, there were 94 acute care facilities with a total of 8,533 acute care beds, and three specialized rehabilitation care facilities, with 468 rehabilitation beds. In addition, there were 19 diagnostic and treatment centres and six Red Cross Outposts.

The Province also provides access to care services for extended care patients. In 1999-2000, there were 17 free-standing extended care facilities. These care units and the associated beds in acute/rehabilitation hospitals provided a total of 8,733 extended care beds.

The number of practising Registered Nurses as of December 1999, was 29,115. British Columbia hospitals also employ Registered Pyschiatric Nurses (RPN) and Licensed Practical Nurses (LPN). In 1998 there were 2,200 RPNs and 5,127 LPNs.

The "Capital Planning Requirements for Health Authorities" document defines the Ministry of Health's expectations of health authority capital planning. The document outlines the processes, policies, timelines, and roles and responsibilities related to health capital projects. The requirements apply to all types of health care facilities, community health centres, ambulance stations, and mental health facilities.

Capital planning needs to be consistent with each regional health authority's vision, mission, needs' assessment, priority issues, goals and strategies as outlined in their three-year health service plans. The health service plan, combined with the age and condition of the components of a health authority's physical inventory, determines the direction for capital planning in a health authority area.

Government responsibility for health capital projects is shared between the Ministry of Health and the Ministry of Finance and Corporate Relations. The Ministry of Health is responsible for needs' assessment and planning, while the Implementation Branch of the Ministry of Finance and Corporate Relations is responsible for project management, financial administration, and project delivery.

Regional hospital districts cost share with the provincial government for a portion of the capital costs associated with health facilities that operate under the authority of the *Hospital Act*. This contribution comes from taxpayers via property taxes levied by regional hospital district boards composed of municipal and electoral area directors under the authority of the *Regional Hospital District Act*.

A number of measures were undertaken in 1999-2000 to improve access and to reduce waiting times for insured hospital services. The Ministry provided health authorities with $45 million in new funds to replace existing equipment, including CT scanners, other x-ray machines, patient monitoring systems and medical equipment. In addition to this funding, the Ministry announced the following specific measures: $50 million to enhance nursing care; $500,000 for a Brachytherapy program for prostate cancer; $427,000 for renovations to the psychiatric unit at Mills Memorial Hospital (a northern referral centre); a mammography unit for Cranbrook; new kidney dialysis service for Cowichan District Hospital; $350,000 for a new neuro-microscope for Victoria General Hospital; $10.76 million to reduce waiting time and improve care for cardiac patients (will provide approximately 700 more surgeries); $6 million to reduce wait times for hip and knee replacements (increase number of surgeries by 1,000); $535,000 to fund three additional beds for St. Paul's Hospital in-patient eating disorder program; and $1.6 million to provide ambulance station emergency unit upgrades for Vancouver General Hospital to open a new trauma operating room and a three-bed trauma special care unit.

5.3 Access to Insured Physician and Dental-Surgical Services

There were 4,276 general practitioners, 3,269 specialists and 265 dentists who provided insured fee-for-service physician and dental-surgical services in 1999-2000.

After months of talks and negotiations, a Framework Memorandum was reached with the British Columbia Medical Association for 1999-2000 and 2000-2001 in January 2000. In addition to extending the terms of the previous Master Agreement and the supplementary Working Agreements, the Framework Memorandum Agreement included a commitment to develop a Rural Agreement that would cover the same term.

Negotiations for a Rural Agreement concluded in April 2000. The Agreement includes an additional allocation of $5.5 million for rural physicians. This will be used to enhance both the Emergency Medical Coverage Program (including on-call payments) ($500,000) and increase subsidies for rural locums to provide for another 900 days of locum coverage (to 3,000 days) at a cost of $400,000, $2 million in additional support for rural specialties, $1 million more for the training of physicians for rural practice, including enhanced Continuing Medical Education subsidies, and a $600,000 contingency fund for special projects and possible additions to Northern and Isolation Allowance communities.

The Rural Agreement also established a joint steering committee to review ways of enhancing the delivery of rural health care and a joint review of the Emergency Medical Coverage Program.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medical Association to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including salaried physicians. Other health care practitioners offering insured services have individual fee schedules approved by the appropriate special committees.

The Master Agreement between the Medical Services Commission, the Government of British Columbia and the British Columbia Medical Association, signed in December 1993, has been extended to March 31, 2001. Key elements include a binding dispute resolution mechanism, and participation by the Association and the Medical Services Commission.

During 1999-2000, the Medical Services Plan's payments to physicians, supplementary benefit practitioners and program management in the Province totaled an estimated $1.96 billion. For physician services provided out-of-province, the Plan paid approximately $20.6 million, of which approximately $16 million was for reciprocal payments to other provinces or territories.

Payment for medical services delivered in the Province is made through the Medical Services Plan to individual physicians, based on billings submitted. The patient is not normally involved in the payment system. Ninety-eight percent of the claims are submitted electronically through the Teleplan System, while the remaining two percent are submitted on claim cards by low-volume physicians and other health care practitioners.

The Medical Services Commission also funds certain medical services through alternative payment arrangements. An Alternative Payments Branch provides funding to some 360 health care agencies that retain physicians to deliver approved programs. Approximately

1,900 physicians have voluntarily entered into alternative payment arrangements with these agencies, and receive part or all of their income through salaries, sessions or service agreements. A variety of alternative payment arrangements is currently being explored, including population-based funding for family practice.

5.5 Payments to Hospitals

Scheduled contribution payments are made by the Ministry of Health, through funding and transfer agreements with regional health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act*, and the *Hospital District Act*. The Health Authorities determine the funding for each hospital in their regions from their Global Budgets.

In 1999-2000, the total funding provided to Health Authorities was $4.4 billion, including funds for hospital, continuing care, health promotion and preventive health and adult mental health programs. Payments to out-of-province hospitals, including those within Canada and outside the country for insured services provided to British Columbia residents totaled $49.5 million in 1999-2000.

6.0 Recognition Given to Federal Transfers

Recognition of federal contributions is given in the Public Accounts of the Province of British Columbia. In addition, recognition of federal contributions was given in public documents for specific joint-funded projects.

7.0 Extended Health Care Services

The Regional Programs Division of the Ministry of Health fund a comprehensive range of community based supportive care services to assist people whose ability to function independently is affected by long term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, community home nursing care, physical therapy, occupational therapy, dietician counselling, social worker services, and meals programs); residential care services (family care homes, group homes, personal intermediate and multi-level care homes, private hospitals, extended-care units); and special support services (adult day centres, respite care, and assessment and treatment centres). Services are delivered at the community level through the health authorities.

Residential care services provide care and supervision in a protective supportive environment for adults who can no longer be looked after in their own homes.

Community home-nursing care services provide professional nursing care to people of all ages in their own homes. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination, and direct nursing care for clients requiring chronic, acute, palliative or rehabilitative services.

Home support services provide non-professional assistance with personal care and housekeeping, and adult day centres offer centre-based programs of health, social and recreational activities.

Yukon

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Hospital Insurance Services Plan. The Health Care Insurance Plan is administered by the Director, Yukon Health Care Insurance Plan, as appointed by the Executive Council Member. The Hospital Insurance Services Plan is administered by the Yukon Hospital Insurance Administrator, as appointed by the Commissioner in Executive Council. The Director of the Yukon Health Care Insurance Plan and the Yukon Hospital Insurance Administrator are hereinafter referred to as the Director of Insured Health Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Hospital Insurance Services Plan.

The *Yukon Health Care Insurance Plan Act* adopted April 1, 1972, sets out the legislative framework for the payment of insured physician services to eligible Yukon residents. The *Hospital Insurance Services Plan Act*, adopted April 9, 1960, sets out the legislative framework for payment to hospitals i.e., amounts in respect of the cost of insured services provided by hospitals to insured persons.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate/function of the Director Yukon Health Care Insurance is to administer the Plan as the chief executive officer of the Plan; determine eligibility for entitlement to insured health services; register persons in the Plan; make payments under the Plan, including the determination of eligibility and amounts; determine the amounts payable for insured health services outside Yukon; establish advisory committees and appoint individuals to advise or assist in the operation of the Plan; conduct actions and negotiate settlements in the exercise of the Government of the Yukon's right of subrogation under this Act to the rights of insured persons; conduct surveys and research programs and obtain statistics for such purposes; establish what information is required under this Act and the form such information must take; appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate/function of the Hospital Insurance Services Administrator is to develop and administer the hospital insurance plan; determine eligibility for and entitlement to insured services; determine the amounts that may be paid for the cost of insured services provided to insured persons; enter into agreements on behalf of the Government of the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons; approve hospitals for purposes of this Act; conduct surveys and research programs and obtain statistics for such purposes; appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts; prescribe the forms and records necessary to carry out the provisions of this Act, and perform such other functions and discharge such other duties as may be assigned by the Regulations.

1.2 Reporting Relationship

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the administrator/director make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and subject to discussion at that level.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the legislature. The report to be tabled in October 2000 covers the fiscal years 1997-1998, 1998-1999, and 1999-2000.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Auditor General's office. The Auditor General of Canada is the auditor of the Government of Yukon in accordance with section 30 of the *Yukon Act* (Canada) and section 8(4)(e) of the *Financial Administration Act* (Yukon). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit was for the year ended March 31, 2000 and the field audit was completed on July 21, 2000.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9 and sections 2, 4, 5, 9 and 11 of the Regulations Respecting Hospital Insurance Services, provide for insured hospital services.

In 1999-2000, insured hospital services to in-patients and out-patients were delivered in 16 facilities throughout the territory. These facilities include one general hospital, one cottage hospital, eight health centres, four nursing stations and two clinics.

Pursuant to the Regulations Respecting Hospital Insurance Services, section 2(e) and (f), services provided in an approved hospital are insured services. Section 2(e), defines "in-patient insured services" as all of the following services to in-patients, namely: accommodation and meals at the standard or public ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability; drugs, biologicals and related preparations as provided in Schedule B, when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; use of radiotherapy facilities where available; use of physiotherapy facilities where available; and services rendered by persons who receive remuneration therefor from the hospital

Section 2(f) of the same regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator provided the service could not be obtained within 24 hours of the accident, namely: necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations of the purpose of assisting in the diagnosis and treatment of an injury; drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine

surgical supplies; services rendered by persons who receive remuneration therefor from the hospital; use of radiotherapy facilities where available; and use of physiotherapy services where available.

2.2 Insured Physician Services

Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 4, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services.

Section 1 of the Act defines "medical practitioner" (physician services), as "a person lawfully entitled to practice medicine in the place in which such practice is carried on by him, and includes any person who performs insured health services". Physicians paid by the Health Care Insurance Plan to provide insured health services must be licensed pursuant to the *Medical Professions Act*. The Act establishes the Yukon Medical Council responsible for the regulation of the professional activities of those persons who practise medicine in the Yukon. The Commissioner in Executive Council appoints six members of the Council and a member of the public service to be the registrar of medical practitioners in the Yukon.

The Registrar of Medical Practitioners is responsible for maintaining a register of every person to be registered as a person authorized to practise medicine in the Yukon (section 9(1)). A physician must meet the following criteria for registration requirements pursuant to section 9(2) of the *Medical Practitioners Act*: make application to the Council for such entry upon the Yukon medical registrar; produce a diploma of qualification issued by a university or college medical school that is recognized by and acceptable to the Executive Council Member acting on the recommendation of the Council; is a licentiate of the Medical Council of Canada; has successfully completed a minimum of 12 months of internship, consisting of training in medicine, surgery, obstetrics and gynaecology, and paediatrics in a hospital recognized by and acceptable to the Executive Council Member acting on the recommendation of the Council; satisfies the requirements of section 13[1]; is examined by the Council and satisfies the members as to his or her general fitness and capacity to engage in the practice of medicine, and pays the prescribed fee or fees fixed in respect of such registration.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations states that "A medical practitioner may elect to collect his fees under the Plan for insured services rendered to insured persons otherwise than from the Plan without loss of benefit to insured persons by giving notice in writing of his election". In 1999-2000, no physicians have provided written notice of their election to collect fees other than from the Health Care Insurance Plan.

Insured physician services in Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Yukon Health Care Insurance Plan are listed in section 3 of the Regulations (see section 2.4). Services not covered by the plan include advice by telephone, medical-legal services, preparation of records and reports, services required by a third party, cosmetic services, and services determined to be not medically required. Two services were added in 1999-2000 to the list of insured physician services: anaesthesia, intubation and paediatrics; emotionally disturbed child–diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives, and written report.

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[1] Section 13 of the *Medical Practitioners Act* requires that persons be legally entitled to reside in Canada; that they be the person to whom the documents of qualification apply, that they be reasonably able to converse in one of the official languages of Canada, that they be in good standing with the medical profession of any jurisdiction where they previously practised medicine, and that they not be subject to criminal charges pending in Canada.

The process used in Yukon to add a physician service to the list of insured services covered by the Health Care Insurance Plan requires that physicians submit requests in writing to have a fee code added to the Relative Value Guide to Fees. The request is then reviewed by the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee. Following review, a decision is made on whether to include or exclude the service. The cost/fee is normally set in accordance with costs/fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the territory must be licensed pursuant to the *Dental Professions Act* and are provided billing numbers for the purpose of billing the Health Care Insurance Plan for the provision of insured dental services. In 1999-2000, two dental surgeons, three oral surgeons and four orthodontists were eligible to bill the Yukon Health Care Insurance Plan for insured dental services.

Insured dental services are limited to those surgical-dental procedures scheduled in the regulations, requiring the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia). Insured surgical dental services include surgical removal of unerupted teeth; alveoloplasty and gigivolplasty; sulcus deepening and ridge construction; exposure of tooth for orthodontic treatment; treatment of traumatic injuries to soft tissues within the mouth; root resection; phrenectomy; excision of intra-oral cysts; excision of benign intra-oral tumours; sialolithotomy; excision of ranula; condylectomy; intra-oral biopsy; incision and drainage of abscess of dental origin; closed reduction of fractures of mandible and maxilla; open reductions of fractures of the mandible and maxilla; closed reduction of temporo-mandibular dislocation; open reduction of temporo-mandibular dislocation; removal of root or foreign body from maxillary antrum; repair and closure of antro-oral fistula; surgical correction of progmathism or micrognathia; therapeutic or diagnostic alcohol nerve block; avulsion of nerve (mental, infra-orbital or interior dental). In the case of children aged 16 years or under, the following surgical-dental services are also insured: oral surgery and orthodontia necessitated by, or consequent to the repair of cleft palate or cleft lip deformity, only where that service arises as part of or following plastic surgical repair; surgical removal of erupted, unerupted or impacted teeth; and such other dental care procedures as determined to be medially necessary by the Director of Insured Health Services.

The addition of new surgical-dental services to the list of insured services requires amendments by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided to members of the Canadian Forces and the Royal Canadian Mounted Police, inmates of federal penitentiaries and Workers' Compensation Health and Safety Board (WCHSB) clients are uninsured under either Plan. Other uninsured services that can be charged to patients include medico-legal services, including examinations and reports relating thereto; testimony in court or provision of evidence in legal proceedings; services that the Director of Insured Health Services determines, on review of medical evidence, is not an insured service because the service rendered was not medically required; detention time; insured services rendered by a medical practitioner to self or any dependants, except where the Director decides otherwise; routine

dental care including dental x-rays; services rendered for third parties; cosmetic services unless specifically approved by the Medical Advisor to the Yukon Health Care Insurance Plan; reversal of sterilization procedures; medical reports or certificates; group immunizations; telephone advice; acupuncture; services provided by podiatrists, osteopaths, naturopaths, orthodontists, chiropractors and physiotherapists; dental surgery performed outside of a hospital; and laboratory and x-ray procedures performed in facilities not approved by the Yukon Health Care Insurance Plan.

Members of the Yukon Medical Association may charge patients directly for services not covered by the Health Care Insurance Plan, including administration, clinical, supplies, telephone prescription renewals, telephone advice, missed appointments etc. Not all physicians and/or clinics charge for these services. Any dental services not performed in a hospital or dental services considered restorative are not covered by the Health Care Insurance Plan.

Uninsured hospital services that can be billed to patients include non-resident hospital stays; drugs and biologicals required following discharge; preferred accommodation surcharges when not medically necessary; special services at the patient's request, such as television charges, and private nursing when not medically necessary. As of March 31, 2000, the standard ward rate for non-Canadians was $1,978, while the intensive care unit (ICU) rate was $2,967.

There are no user fees or co-insurance charges under the Hospital Insurance Services Plan. Hospital beds are readily available. No waiting list for admission exists. Yukon has one newly constructed acute care facility located in Whitehorse, where the number of beds staffed and in operation as of March 31, 2000 was 49, with space available to open eight additional acute care beds should future occupancy trends indicate that a higher number of beds are required.

All Yukon residents have equal access to services. Third parties such as private insurers or the WCHSB are not given priority access to services. The territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director of Insured Health Services to monitor usage and service concerns.

The purchase of non-insured services such as fibreglass casts does not delay or prevent access to insured services at any time. Insured persons are provided treatment options at the time of service. The territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director of Insured Health Services to monitor usage and service concerns.

The process used to de-insure services covered by the Yukon health care insurance plans is as follows:

- **Physician services** - the Yukon Medical Association/Insured Health Services Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service all physicians are provided notification in writing. The Director manages this process.
- **Hospital services** - an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. To date no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. The Administrator is responsible for managing this process in conjunction with the Yukon Hospital Corporation.

- **Dental-surgical services** - an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required.

Only one service was removed from the Relative Value Guide to fees in 1999-2000, as follows: Diagnostic Procedures - Simple Screening Spirometry using portable apparatus.

3.0 Universality

3.1 Eligibility

Eligibility for the Health Care Insurance plan is defined under section 2 of the *Health Care Insurance Plan Act*, section 4 of *Regulations Respecting Health Care Insurance*, section 2 of the *Hospital Insurance Services Act* and section 4 of the *Yukon Hospital Insurance Service Regulations*. Subject to the provisions of these Acts and their regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and "means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon."

Under section 4(3) of both health care insurance acts "an insured person is eligible for insured services after midnight on the last day of the second month following the month of arrival in the Yukon."

Those entitled to or eligible for benefits under any other Act, under any law of a province or under any Act of the Canadian Parliament other than the *Canada Health Act*, are not entitled to benefits. This includes but is not limited to members of the Canadian Armed Forces; members of the Royal Canadian Mounted Police; and inmates in federal penitentiaries.

Persons who provide a date of discharge or release from the RCMP, armed forces or a federal penitentiary become eligible for coverage under the Health Care Insurance Plan on the day following the specified date.

3.2 Registration Requirements

Persons moving to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form, which is available from the Insured Health Services office or community Territorial Agents. Once approved, a health care card is mailed to the applicant. Family members receive separate health care cards and numbers. Coverage expires every year on the resident's birthday and an updated label(s), with the new expiry date is mailed out each year.

If other family members move to the Yukon in advance of a remaining spouse residing elsewhere in Canada, the originating province/ territory will cover all family members for the same period of time as the remaining spouse, to a maximum of 12 months, in accordance with the Interprovincial Agreement on Eligibility and Portability.

As of March 31, 2000, there were 31,225 residents registered with the Yukon Health Care Insurance Plan.

Section 16 of the *Health Care Insurance Plan Act* states that "every resident other than a dependant or a person exempted by the regulations from so doing, shall register himself and his dependants with the Director of Insured Health Services, at the place and in the manner and form and at the times prescribed by the regulations."

3.4 Other Categories of Individual

Conditions regarding eligibility for coverage that apply to special categories of individual are as follows:

- Returning Canadians and landed immigrants: no waiting period (section 4(3) Yukon Health Care Insurance Plan Regulations and section 4(3) Yukon Hospital Insurance Services Regulations);
- Authorized Minister's Permit: no waiting period if eligible;
- Convention Refugees: eligible if the individual has an Employment Authorization for one year; and
- Authorized Temporary Residents (e.g., Employment Authorizations and permits other than Minister's Permits: no waiting period).

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to the Yukon are entitled to coverage pursuant to section 4(3) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services (YHIS) Regulations. Section 4(3) states that "an insured person is eligible for insured services after midnight on the last day of the second month following the month of arrival in the Yukon".

4.2 Coverage During Temporary Absences In Canada

The provisions relating to portability of health insurance during temporary absences in Canada are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence".

With regard to coverage for out-of-province students, the Director of Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director. For temporary workers, the Director of Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director of Insured Health Services. For missionaries, the Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability, as of January 1, 1998. Definitions have been rendered consistent in regulations, policies and procedures.

Yukon participates fully with the Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories (Quebec does not participate in the medical reciprocal billing arrangement). Insured services provided to Yukon residents while temporarily absent from the territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 1999-2000.

In-patient services	Out-patient services
$4,882,020	$917,660
Note: Figures do not include out-of-country costs and are by date of service.	

In 1999-2000 payments to out-of-territory physicians totalled $1,572,022. (Note: figures include out-of-Canada costs and are by payment date).

The Hospital Reciprocal Billing Agreements provide payment of in-patient and out-patient hospital services to eligible Yukon residents receiving insured services outside the territory. High cost procedure rates, newborn rates and out-patient rates are derived by the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing. These rates are established by Order-In-Council under the Charges for Out-Patient Procedures Regulation, Standard Ward Rates Regulation and Charges for In-Patient High-Cost Procedures Regulation.

The Medical Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Yukon residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health insurance during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

Sections 5 and 6 state that "Where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

The provisions for portability of health insurance during out-of-country absences are similar to those in effect for absences within Canada as described under section 4.2. Similar provisions also apply for out-of-country students, temporary workers and missionaries.

With regard to coverage for out-of-country students, the Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director. With regard to temporary workers, the Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director. For missionaries, the Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Yukon.

Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. Reimbursement is made for elective and emergency services. Exceptions may be made where services received outside the territory are not available in Yukon. Remuneration is based on the standard ward rate of the nearest approved facility in Canada. Prior approval is required. The standard ward rate for the Whitehorse General Hospital as of March 31, 2000 was $989. The rate is established through Order-In-Council and is derived at as follows:

- total operating expenses less non-related in-patient costs, less related newborn costs, less associated out-patient costs divided by total patient days less patient days for other services (ex. non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents are paid at the rate established in the Charges for Out-Patient Regulation. The out-patient rate is currently $110 and is established through Order-in-Council and is derived by the Canadian Coordinating Committee on Reciprocal Billing.

The following amounts were paid for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
$22,125	$7,080
Note: Figures are by service date.	

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency services outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Health Care Insurance Plan or the Hospital Insurance Services Plan. Access to specialists and services not available locally are available through a visiting medical specialist program and a publicly funded travel for medical treatment program. There is no extra-billing in Yukon for any services covered by the Health Care Insurance Plan.

5.2 Access to Insured Hospital Services

Hospital beds are readily available and no wait list for admission exists. Yukon has one newly constructed acute-care facility located in Whitehorse – the Whitehorse General Hospital. Beds staffed and in operation as of March 31, 2000 totaled 49 with an additional eight acute care beds that can be made available should future occupancy trends indicate a need. The Watson Lake Cottage Hospital facility has twelve beds and no wait list for admission exists. Yukon has no rehabilitative beds. Patients are referred out-of-territory for these services.

Outside the Whitehorse General Hospital, only four facilities provide limited in-patient services and have resident physicians: the Watson Lake Cottage Hospital, Dawson Nursing Station, Faro Nursing Station and Mayo Nursing Station. Out-patient and 24-hour emergency services are provided by all 13 community nursing stations, health stations, health centres and the cottage hospital. Health Units are staffed by one or more nurses and auxiliary staff.

The Whitehorse General Hospital currently employs 103 nurses, representing 72¾ full-time equivalent (FTE) positions. A full complement requires 75¾ FTE positions.

The Whitehorse General Hospital is the only acute care facility in Yukon. In-patient, out-patient, and 24-hour emergency services are provided. Emergency services are provided on rotation by local physicians. Medical services provided include intensive care services (surgical and cardiac), respiratory services (chronic obstructive pulmonary diseases, asthma etc.) , cardio vascular accidents, maternity, gastro-intestinal bleeds, cellulitis, chemotherapy, hypertension and general failure to thrive/weakness. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, mastectomy, emergency trauma, ear/nose/throat/ otolaryngology, opthalmology including cataracts. Patients requiring specialized surgeriesare sent to outside centres. Diagnostic services include radiology, laboratory, mammography, and electrocardiogram. Rehabilitative services are limited.

There is no wait list for admission to the Whitehorse General Hospital. Emergency day surgery patients are normally seen within 24 hours. Non-emergency day and routine surgery patients are normally seen within one to two weeks. Visiting specialist clinics are routinely increased to reduce wait times, particularly for orthopaedics, ear/nose/throat and opthalmology (see section 5.3). For services not available locally, the Visiting Specialist Program provides services and the Travel for Medical Treatment Program is available to assist eligible persons with the cost of medically necessary transportation for emergency and non-emergency insured services.

In April, 1998 the Yukon Departments of Health and Social Services and Government Services, together with NorthwesTel successfully applied to the Canadian Network for the Advancement of Research, Industry and Education (CANARIE) for funding to pilot a telemedicine project in Dawson City, Ross River and Teslin. The purpose was to enable the departments to test the use of telemedicine in improving accessibility to medical services and thereby improving quality of care. The pilot began in July 1998 and was completed on June 30, 1999.

Based on the success of the 1998 telemedicine project, application for funding has been made to the Canada Health Infostructure Partnerships Program (CHIPP), to do real time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta.

5.3 Access to Insured Physician and Dental-Surgical Services

The following physicians, specialists and dentists provide services in the Yukon:

General Practitioners/Family Practitioners	41
Specialists	5
Dentists	9

The following specialists provide services under the visiting specialist program:

Ophthalmologist	1
Oncology	3
Orthopaedics	4
Internal Medicine	1
Otolaryngology	2
Neurologist	1
Rheumatologist	1
Dermatologist	1
Dental Surgeon	1

Visiting specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2000, the wait list for non-emergency specialist services was as follows:

Ophthalmologist	3-6 months
Orthopaedics	6 months
Otolaryngology	8-10 months
Dental Surgeon	2-3 months

Most physicians in the Yukon are located in Whitehorse. Outside Whitehorse only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Contracted physicians have been placed in the communities of Faro and, most recently (February 2000), Mayo, Yukon. Placement of another contracted physician is currently being considered.

A visiting physician program provides access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians who provide visiting services are compensated for lost practice time, mileage, meals and accommodation.

The Travel for Medical Treatment Program assists eligible residents with the cost of medically necessary transportation from rural areas to access physician and hospital services not available locally.

The Department of Health and Social Services and the Yukon Medical Association are collaborating on strategies that will address the current need for physicians and locums in Yukon. Several options are under consideration.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, prior to entering negotiations with the Yukon Medical Association (YMA). The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department of Health and Social Services seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent negotiations were concluded on December 14, 1999. The Memorandum of Understanding is effective from April 1, 1999 through March 31, 2002.

The legislation governing payments to physicians and dentists for insured services are the *Yukon Health Care Insurance Plan Act* and the Yukon Health Care Insurance Regulations.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. Currently, two rural physicians are compensated on a contractual basis.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital), through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated based on operational requirements and utilization projections for prior years. The current three-year contribution agreement is in effect to March 31, 2001.

In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for purchasing new or enhanced programs.

Only the Whitehorse General Hospital is funded through contribution agreements. The one cottage hospital and all nursing stations and health centres are funded through the Yukon Government's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Hospital Insurance Services Plan Regulations. The legislation and regulations sets out the legislative framework for payment to hospitals of amounts in respect of the cost of insured services provided by that hospital to insured persons.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon Territory has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its annual Main Estimates and Public Accounts publications.

7.0 Extended Health Care Services

Intermediate care is available at the Maccaulay Lodge (Whitehorse). The facility provides 24-hour care and is fully staffed with professional and para-professional staff. MacDonald Lodge in Dawson City provides nursing services between 9:00 a.m. and 5:00 p.m. After-hours services is personal care only. After-hours medical attention is provided by the community nursing station.

Nursing home services are available at the Thomson Centre. The facility provides the highest level of long term care in Yukon, including extensive chronic care services up to the level of acute care services. Acute care cases are transferred to the Whitehorse General Hospital. Also, nursing home services are provided in hospital for patients waiting admission to the Thomson Centre (no beds available) using the same rate as is charged to Thomson Centre patients of $21 per day.

In addition, the Home Care Program assists Yukoners who are not fully able to care for themselves at home. A community based visit service that encourages self-sufficiency and supports family members and community involvement enables individuals to remain safely in their own homes.

In addition to the services described in the previous sections, the following services are available to eligible Yukon residents:

Chronic Disease and Disability Benefits Program: provides benefits for Yukon residents who have a chronic disease or a serious functional disability and coverage of related prescription drugs and medical-surgical supplies and equipment.

Pharmacare Program & Extended Benefits Programs: designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services, and medical-surgical supplies and equipment.

Travel for Medical Treatment Program: assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation.

Children's Drug and Optical Program: designed to assist low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 years of age and younger.

Public Health: designed to promote health and well-being throughout the territory through a variety of preventive and education programs.

Ambulance Services Program: responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care.

Northwest Territories

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The name of the plan in the Northwest Territories (N.W.T.) is "The Northwest Territories Health Care Plan", which includes the "Medical Care Plan", and the "Hospital Insurance Plan". The public authority responsible for the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through boards of management appointed under the *Hospital Insurance and Health and Social Services Act*.

Legislation that enables the plan in the Northwest Territories includes the *Medical Care Act* and the *Hospital Insurance and Health and Social Services Administration Act*. Both the *Medical Care Act* and the *Hospital Insurance and Health and Social Services Administration Act* were passed in 1988.

The mandate of the Director of Medical Insurance is to deliver services as described in detail in the *Medical Care Act*. The mandate of the Minister is outlined in the *Health Insurance and Health and Social Services Act*.

1.2 Reporting Relationship

In the N.W.T., the Minister of Health and Social Services appoints a Director of Medical Care. The Director is responsible for the administration of the *Medical Care Act* and the Regulations. The Minister also appoints members to the Board of Management for facilities located throughout the Northwest Territories. The Chairperson holds office during the pleasure of the Minister, while the remaining members hold office for a term of three years. Accounts of the Boards of Management must be audited every year.

An annual audit of accounts is done at each Board of Management. The Chairperson of each Board of Management has regular meetings with the Minister, and uses that forum to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Auditor General of Canada has the mandate to audit the payments made under the Medical Care Plan. The accounts of every Board of Management must be audited annually by an auditor appointed by the Minister pursuant to the *Financial Administration Act*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act and the Regulations*. As of March 31, 2000, the Northwest Territories had four hospitals and 28 health centres that delivered insured hospital services to in- and out-patients.

The Northwest Territories provides a full range of insured hospital services. Boards of Management have the authority to provide services above those considered medically necessary, although those services are not covered by the insurance plans.

Insured in-patient services include accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and services rendered by an approved detoxification centre.

Out-patient services include laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy and speech therapy services in an approved hospital; and psychiatric and psychology services provided under an approved hospital program.

The Minister makes the determination to add insured hospital services. The Minister will also determine if any public consultation will occur.

Where services are not available in the N.W.T., residents receive services from hospitals in other jurisdictions.

2.2 Insured Physician Services

The *Medical Care Act* and the Medical Care Regulations provide for insured physician services in the Northwest Territories. Medical doctors are the only medical practitioners allowed to deliver insured physician services in the Northwest Territories. The physician must be in good standing with the College of Physicians and Surgeons and be licensed to practice in the Northwest Territories. Although physicians may opt out or de-enroll in the Northwest Territories, none have chosen to do so.

The Northwest Territories provides a broad range of medically necessary services. If a service has been deemed an insured service, no limitations are applied.

The Medical Care Plan insures all medically required procedures provided by medical practitioners, including approved diagnostic and therapeutic services; necessary surgical services; complete obstetrical care; eye examinations; and visits to specialists, even when there is no referral by a family physician.

In negotiations between the Northwest Territories Medical Association and the Director of Medical Insurance, additional medical services may be added to the list of insured services available in the N.W.T. The process of adding a service is managed by the Director of Medical Insurance who determines if public consultations are appropriate.

2.3 Insured Surgical-Dental Services

If the service is an insured service and related to oral surgery, injury to the jaw, or disease of the mouth/jaw it is eligible. Only oral surgeons may submit claims for billing.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Some services provided by hospitals, physicians, and dentists that are not covered by the health care insurance plan of the Northwest Territories include medical-legal services, third-party examinations, services not medically required, group immunization, *in vitro*-fertilization, services provided by a doctor to his or her own family, telephone advice or prescriptions given over the phone, surgery for

cosmetic purposes except where medically required, dental services other than those specifically defined services for oral surgery, dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, and surgical appliances or special bandages; treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners; physiotherapy and psychology services received from other than an insured out-patient facility; services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and routine annual check-ups where there is no definable diagnosis.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* is the legislation that defines the eligibility of Northwest Territories residents to the health care insurance plan of the Territory.

The Northwest Territories uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the Northwest Territories Health Care Plan Registration Guidelines to define eligibility. No changes have been implemented to eligibility in 1999-2000.

Ineligible individuals for Northwest Territories health care coverage are members of the Canadian Armed Forces, RCMP members, federal inmates, and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form, and supporting documentation as applicable, i.e. visas, immigration papers, etc. The individual must be prepared to provide proof of residency if requested. Registration should optimally occur prior to the actual eligibility date of the client. Renewal of health care cards is done every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of March 31, 2000, approximately 41,000 clients were registered with the Northwest Territories Health Care Plan.

No formal provisions are in place for clients to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas, and in some cases visitor visas are covered if they hold valid visas for a period of 12 months or more.

4.0 Portability

4.1 Minimum Waiting Period

Waiting periods are imposed as per the Interprovincial Agreement on Eligibility and Portability for insured persons moving into the Northwest Territories from other jurisdictions, generally until the first day of the third month, or until the first day of the thirteenth month in some cases.

4.2 Coverage During Temporary Absences In Canada

The Interprovincial Agreement on Eligibility and Portability and the Northwest Territories Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the Northwest Territories while they are in full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the Northwest Territories for work, vacation, secondments etc. When an individual is approved as being temporarily absent from the N.W.T., the full costs for insured services are paid for all services received in other jurisdictions.

The Northwest Territories participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The Northwest Territories Health Care Plan Registration Guidelines set out the criteria to define coverage for absences outside of Canada. Individuals are granted coverage for up to one year if they are out-of-country for any reason.

As per section 11. (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. Reimbursement is determined by applying the applicable Northwest Territories rate for the same service.

4.4 Prior Approval Requirement

Prior approval is required for uninsured services, or services obtained in private facilities throughout Canada and outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Assistance supplementary health benefit program ensures that economic barriers are reduced for all Northwest Territories residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Accessibility of beds has not been a problem in the Northwest Territories. If such a case arises, the resident is transported to another facility where appropriate beds exist. At March 31, 2000, hospitals and nursing stations in the Northwest Territories faced some short-term staffing difficulties which had negative impacts on functions. However, through use of Medical Travel, access to services was maintained.

The Northwest Territories recognizes that our facilities do not have sufficient capacity to offer an extensive range of medical surgical, rehabilitative and diagnostic services. The Medical Travel Assistance program is in place to ensure that residents are able to access the required services at facilities where available.

Measures taken in 1999-2000 to improve access to insured hospital services include the expansion of the telehealth program. Waiting lists for insured hospital services in the Northwest Territories are low. Therefore, the reduction of waiting time has not been a targeted project.

5.3 Access to Insured Physician and Dental-Surgical Services

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories.

The Medical Travel Assistance program provides access to physicians for residents and the telehealth program has provided an expansion of specialist services to residents in isolated communities.

5.4 Physician Compensation

The Government of the Northwest Territories and the Northwest Territories Medical Association have negotiated an agreement, subsequently signed into law, as regulations of the *Medical Care Act*. These regulations covered the period starting April 1997 through March 31, 2000.

During 1998-1999, payments to Northwest Territories physicians totalled approximately $16,734,947. The Plans paid approximately $3,550,515 for physician services provided outside the territories, for a total of $20,300,838.

Fee-for-service physician compensation is determined by negotiations between the Northwest Territories Medical Association and the Department of Health and Social Services. The Director of Medical Insurance and his or her designates negotiate on behalf of the Department and Northwest Territories Medical Association chooses a negotiation team from within their membership.

The *Medical Care Act* and the *Medical Care Regulations* are used in the Northwest Territories to govern payments to physicians. The Northwest Territories uses the fee-for-service model and employee contracts to compensate physicians.

5.5 Payments to Hospitals

Payments are made to hospitals based on contribution agreements between the Boards of Management and the Department of Health and Social Services. Amounts allocated in the agreements are based upon the resources available in the total government budget and level of service provided by the hospital.

Although there is no specific legislation in place to specifically govern payments to facilities providing insured hospital services, portions of the *Hospital Insurance and Health and Social Services Act* and the *Financial Administration Act* are applied to the payment process. No amendments have been implemented to the process in 1999-2000. A global budget is used to fund hospitals in the Northwest Territories.

6.0 Recognition Given to Federal Transfers

During the 1999-2000 fiscal year, the Northwest Territories did not produce any public documents, advertising, or promotional material that would appropriately recognize the financial contributions received from the federal government.

7.0 Extended Health Care Services

Nursing home-level care is supported by the Hospital Insurance Plan and provided in designated beds in facilities located in Inuvik, Yellowknife, Hay River, and Fort Smith. Where appropriate services are not available in the Northwest Territories, clients are accommodated in facilities in southern Canada. Under the authority of the Boards of Management, the nine coordinated home care programs deliver home care services throughout the Northwest Territories.

Nunavut

NOTE: Nunavut was formed as a Territory on April 1,1999. Legislation governing the administration of health and social services in the Northwest Territories continued to be in effect for the purposes of the programs referred to in this report.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act,* 1988, governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act,* 1988, enables the establishment of hospital and other health services. This *Act* also permits the Minister of Health to establish Boards of Management for the administration of health and social services on a regional basis. In 1999-2000 Nunavut administered regulations governing three regional boards: Baffin, Kitikmeot and Keewatin.

1.2 Reporting Relationship

The Minister of Health and Social Services appoints the Director of Medical Care, who is responsible for the administration of the Medical Care Insurance Plan. The Director reports to the Minister and ensures that an annual report is provided to the Minister for each fiscal year to be tabled at a session of the Legislative Assembly. As this is the first year of operation as a Territory, the reports for 1999-2000 have not been completed.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act of Nunavut.* The Auditor General has the mandate to audit the activities of the Department of Health and Social Services. Each Board of Management is required to prepare a financial audit and submit it to the Department within three months of the end of the fiscal year.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit for the fiscal year ending March 31, 2000, is currently being conducted. The field work is expected to be complete by the end of this fiscal year.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital and Social Services Administration Act and Regulations,* 1988, sections 2 to 4.

In 1999-2000, insured hospital services were delivered in 26 facilities throughout Nunavut, including one general hospital located in Iqaluit and 25 community health centres. The Iqaluit hospital is the only acute care facility in Nunavut providing a range of in-patient and out-patient hospital services, as defined by the *Canada Health Act.* Community health centres provide

public health, emergency room services and some overnight services (observations). There are a limited number of birthing beds in Nunavut. The majority of in-patient services are provided at the hospital in Iqaluit. The Department is responsible for authorizing, licensing, inspecting and supervising health facilities and social services facilities in the Territory.

Insured in-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- drugs, biologicals and related preparations prescribed by a physician and administered in hospital;
- routine surgical supplies;
- use of operating room, case-room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available;
- psychiatric and psychological services provided under an approved program;
- services rendered by persons who are paid by the hospital; and
- services rendered by an approved detoxification centre.

Out-patient services include:

- laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
- hospital services in connection with most minor medical and surgical procedures;
- physiotherapy, occupational therapy and speech therapy services in an approved hospital; and
- psychiatric and psychology services provided under an approved hospital program.

The three Regional Boards make the determination to add insured services in their facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and Financial Management Board. No new services were added in 1999-2000 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1) and Medical Care Regulations, section 3, provide for insured physician services in Nunavut.

Medical doctors are the only medical practitioners permitted to deliver insured physician services in Nunavut. The physician must be in good standing with the College of Physicians and Surgeons and be licensed to practise in Nunavut. The Government of the Northwest Territories manages this process for Nunavut physicians. There are 11 physicians living in Nunavut who provide services to Nunavut patients. Visiting specialists, general practitioners and locums, through arrangements made by each Board, also provide insured physician services.

Physicians can make an election to collect fees otherwise than under the Medical Care Plan in accordance with section 12 (2)(a) or (b) by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 1999-2000, no physicians provided written notice of this election.

Insured physician services means all services rendered by medical practitioners that are medically required. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. No services were added in 1999-2000, although some new fee codes came into existence.

The process used in Nunavut to add a physician service to the list of insured services covered by the Medical Care Insurance Plan is based on the process used by the Government of the Northwest Territories (N.W.T.) whereby the Director of the NWT plan negotiates with the N.W.T. Medical Association over additions or reductions to the list of insured services.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the territory must be licensed pursuant to the *Dental Professions Act* and are provided billing numbers for the purpose of billing the Plan for the provision of insured dental services. In 1999-2000, three oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the regulations, requiring the unique capabilities of a hospital for their performance, for example, orthognathic surgery.

The addition of new surgical-dental services to the list of insured services requires government approval.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided for under the *Workers' Compensation Act* or other Acts of Canada, except the *Canada Health Act,* are excluded.

Services provided by physicians that are not insured include:

- yearly physicals;
- cosmetic surgery;
- services that are considered experimental;
- prescription drugs;
- physical examinations done at the request of a third party;
- optometric services;
- dental services other than specific procedures related to jaw injury or disease;
- the services of chiropractors, naturopaths, podiatrists, osteopaths, and acupuncture treatments; and
- physiotherapy, speech therapy, psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include:

- hospital charges above the standard ward rate for private or semi-private accommodation;
- services that are not medically required, such as cosmetic surgery;
- services that are considered experimental;
- ambulance charges (except inter-hospital transfers);
- dental services, other than specific procedures related to jaw injury or disease;
- alcohol and drug rehabilitation, unless prior approved.

The hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

The Government of Nunavut relies on the policies and procedures guiding other jurisdictions when providing services to Nunavut residents that could result in additional costs related to residents. Any query or complaint is handled on an individual basis with the jurisdiction involved.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Eligibility and Portability Agreement as well as internal guidelines.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor to the Territory. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number. Coverage generally begins the first day of the third month after arrival in the Territory but first-day coverage is provided under a number of circumstances, e.g., newborns whose mothers or fathers are eligible for coverage.

Members of the Canadian Armed Forces, Royal Canadian Mounted Police and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage upon discharge. Persons residing in Nunavut who are temporarily absent from another province remain covered by their home provincial/territorial health insurance plan for up to one year.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut has adopted the two-year renewal process in place in the N.W.T. but will be assessing this decision in the future. No premiums exist. Coverage is linked to registration although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident.

As of March 31, 2000, there were approximately 27,000 residents registered with the Nunavut Health Care Plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plans.

3.3 Other Categories of Individual

Holders of employment visas of less than 12 months, student visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis.

4.0 Portability

4.1 Minimum Waiting Period

Generally, the waiting period before coverage begins for individuals moving within Canada is three months or the first day of the third month following the establishment of residency in a new province or territory or the first day of the third month when an individual who has been temporarily absent from his or her home province decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences In Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o) provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment.

Students studying outside Nunavut must notify the Department and provide proof of enrollment to ensure coverage continues. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability, as of January 1, 1998.

Nunavut participates in Physician and Hospital Reciprocal Billing; and agreements are in place with other provinces and territories. The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services out-side the territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services.

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

$14,608,302.66 was paid to out-of-territory hospitals for the fiscal year 1999-2000.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3) prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o) provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made to the insured person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients if required in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital, located in Iqaluit, is the one acute care hospital facility in Nunavut. In 1999-2000, the hospital had on average 16 staffed beds available for acute, rehabilitation and chronic care services. The hospital has a staff of 84, including 29 nurses. The facility provides in-patient, out-patient, and 24 hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, gastrointestinal bleeds and hypertension treatment. Surgical services provided include minor orthopedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit. Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill (Manitoba), Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Intermediate Care is available at St. Theresa's Hospital. The facility provides 24 hour care and is fully staffed with professional and para-professional personnel. The facility located in Chesterfield Inlet provides nursing services between 7 a.m. and 7 p.m. After-hours services is personal care only. After-hours medical attention is provided by the community nursing station.

Nursing Home services are available at the Iqaluit and Atviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut, that is, extensive chronic care services up to the point of acute care (level 4and 5) services. Acute care cases are transferred to the closest hospital.

Outside the Baffin Regional Hospital, out-patient and 24 hour emergency services are provided by all 25 health centres located in communities.

Although nursing and other health professionals were not at the desired levels of staffing, all basic services were provided in 1999-2000. Nunavut is seeking to increase resources in all areas.

The use of telehealth services has been a significant step in improving access to hospital and medical and other health and social services in Nunavut. Pilots are underway in three communities. The long-term goal is to integrate telehealth into the primary care delivery system and enable residents of

Nunavut greater access to a broader range of service options for residents, providers and communities and to use existing resources more effectively.

5.3 Access to Insured Physician and Dental-Surgical Services

In addition to the medical travel assistance and telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. In 1999-2000, there were 85 general practitioners/ family practitioners and 79 specialists/dentists providing services in Nunavut.

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry dental surgeons. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There are two fee-for-service physicians residing in Nunavut and they are paid on the same basis as Northwest Territories physicians. Because these physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20percent greater than the amounts set out in the schedule, (per the *Medical Care Act* section 4). The fees are negotiated between the N.W.T. Medical Association and the Department of Health and Social Services. The remaining physicians are on contract at a per diem rate or are on salary. Visiting specialists are paid on a per diem basis under the terms of their contracts.

5.5 Payments to Hospitals

The Government of Nunavut funds the Nunavut Hospital and the community health centres through global contributions to the regional boards. Payments are made to the hospital and community health centres on a monthly basis from the Department of Health and Social Services to the three Boards of Management. The current contribution agreements are in effect to March 31, 2000.

6.0 Recognition Given to Federal Transfers

No material was produced in 1999-2000.

7.0 Extended Health Care Services

A Home Care Program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visit service encourages self-sufficiency, supports family members and community involvement to enable individuals to remain safely in their own homes.

Annex A

Introduction

This Annex is new to the *Canada Health Act Annual Report* for 1999-2000. The purpose of the Annex is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are under the scope of the Act.

The Annex contains statistical data on the cost and utilization of insured hospital and medical services for each province and territory for four consecutive fiscal years: 1996-1997, 1997-1998, 1998-1999, and 1999-2000 (each fiscal year ends on March 31).

All information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, all provincial/territorial submissions were guided by a statistical template which Health Canada shared and discussed with representatives in each province and territory.

The annex is organized in the same manner as the provincial/territorial health care insurance plan descriptions. There is no subsection for Quebec, as that province chose not to submit information in the manner and detail requested by Health Canada as discussed in the opening to the description of Quebec's health care insurance plan.

Organization of the Information

Information for each province and territory is organized according to the six subcategories described below. Statistics which were available as of November 2000, have been reported. In some cases data were not yet available and estimates were provided. In other cases, no information was available or the requested statistic did not apply to the particular province or territory.

For a more detailed discussion on some of the data shown in these tables, please refer as well to the section of this publication entitled *Provincial and Territorial Health Care Insurance Plans*.

In-Province/In-Territory Hospital Services

Statistics in this subsection relate to the provision of insured hospital services within each jurisdiction to residents of the jurisdiction and to visitors from other provinces or territories.

Details include: numbers of facilities by type; number of beds; number of separations or admissions; average length of stay in each type of facility; total payments in the province/territory per category of facility; average per diem for each type of facility; and details relating to payments to private facilities.

Hospital Services Provided Out-of-Province/Out-of-Territory (in Canada)

Out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada are shown in this subsection. The information reported includes the total number of claims paid for insured hospital services in other provinces or territories, total payments made, and the average payment level.

Hospital Services Provided Out-of-Country

Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are the same as for hospital services provided out-of-province or out-of-territory.

In-Province/In-Territory Physician Services

Statistics in this subsection relate to the provision of insured physician services to residents in each province or territory as well as to visitors from other regions of Canada.

Details include: the number of physicians participating in the provincial or territorial health insurance plan; the number of insured services provided; the total payments made to physicians by category of physician and by category of service; and the average payment level per insured physician service.

In-Province/In-Territory Surgical-Dental Services

The information in this subsection describes insured surgical-dental services provided in each province and territory. This includes: the number of participating professionals (dentists, dental surgeons, and oral surgeons); the number of services provided; total payments made in the fiscal year; and the average payment per service.

Out-of-Province/Out-of-Territory Physician Services

This subsection reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents. Statistics include the number of services paid, total payments made, and the average payment level per service.

Newfoundland and Labrador

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
- acute care facilities[1]	34	34	34	34
Total facilities	34	34	34	34
2. Number of staffed beds in facilities providing insured hospital services, by category:				
- acute care beds	1,860	1,842	1,814	1,807
- rehabilitative care beds	38	38	62	57
Total staffed beds	1,898	1,880	1,876	1,864
3. Approved bed complements in facilities providing insured hospital services, by category:				
- acute care beds	1,860	1,842	1,814	1,807
- rehabilitative care beds	38	38	62	57
Total approved bed complement	1,898	1,880	1,876	1,864
4. Number of separations from facilities providing insured hospital services, by type of care:				
- acute care beds	68,766	67,385	68,729	66,828
- rehabilitative care beds	108	54	227	272
Total separations	68,874	67,439	68,956	67,100
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of facility:				
- acute care facilities	8.0	7.9	7.5	7.4
6. Total payments to facilities providing insured hospital services, by type of facility:[2]				
- acute care facilities	$431,336,662	$441,408,824	$457,065,782	$509,018,766
Total payments to all facilities providing insured hospital services	$431,336,662	$441,408,824	$457,065,782	$509,018,766

[1] Acute care facilities provide mainly acute care services, but some facilities also provide rehabilitative and long term care services.

[2] Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:				
- acute care facilities	$675.00	$675.00	$690.00	$690.00
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services:				
- acute care facilities	not available	not available	not available	not available
- chronic care facilities	not available	not available	not available	not available
- rehabilitative care facilities	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facility:				
- acute care facilities	not available	not available	not available	not available
- chronic care facilities	not available	not available	not available	not available
- rehabilitative care facilities	not available	not available	not available	not available
10. Number of private health care facilities providing insured health services:				
- private surgical facilities	0	1	1	1
- private diagnostic facilities	0	0	0	0
Total	0	1	1	1
11. Number of insured health services provided at:				
- private surgical facilities	0	not available	not available	not available
- private diagnostic facilities	0	0	0	0
Total	0	not available	not available	not available
12. Total payments to				
- private surgical facilities	0	$53,808	$212,990	$387,030
- private diagnostic facilities	0	0	0	0
Total	0	$53,808	$212,990	$387,030

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	1,796	1,970	1,826	1,549
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	22,187	26,293	28,739	25,546
15. Total payments for out-of-province, in-patient, insured hospital occurrences (in-Canada).	$11,550,785	$11,285,682	$12,037,091	$10,144,354
16. Total payments for out-of-province, out-patient, insured hospital occurrences (in-Canada).	$2,048,471	$2,856,772	$3,316,482	$3,138,582
17. Average payment for out-of-province, in-patient insured hospital occurrences (in-Canada).	$6,431	$5,729	$6,592	$6,549
18. Average payment for out-of-province, out-patient hospital occurrences (in-Canada).	$92	$101	$115	$123

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	72	39	42	73
20. Total number of claims paid for out-of-country out-patient, insured hospital services.	366	374	363	260
21. Total payments for out-of-country, in-patient, insured hospital services.	$144,887	$161,364	$503,043	$198,072
22. Total payments for out-of-country, out-patient, insured hospital services.	$33,298	$38,985	$56,614	$15,626
23. Average payment for out-of-country, in-patient insured hospital services.	$2,012	$2,241	$6,449	$2,713
24. Average payment for out-of-country, out-patient hospital services.	$91	$104	$156	$60

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:[3]				
- general practitioners	not available	524	549	not available
- specialists	not available	453	470	not available
- all physicians	not available	977	1,019	not available
26. Number of insured services provided, by category of physicians (fee-for-service):				
- general practitioners	2,783,000	2.,623,000	2,471,000	not available
- specialists	2,206,000	2,407,000	2,440,000	not available
- all physicians	2,989,000	5,030,000	4,911,000	not available
27. Number of insured physician services provided, by category of services:				
- medical services	3,257,000	3,195,000	3,107,000	not available
- surgical services	447,000	487,000	487,000	not available
- diagnostic services	1,285,000	1,348,000	1,317,000	not available
- all insured physician services	4,989,000	5,030,000	4,911,000	not available
28. Total payments to (fee-for-service) physicians for insured services, by category of physicians:				
- general practitioners	$ 44,392,000	$ 40,956,000	$ 41,521,000	not available
- specialists	$ 61,611,000	$ 67,314,000	$ 71,640,000	not available
- all physicians	$106,003,000	$108,270,000	$113,161,000	not available
29. Total payments to fee-for-service physicians for insured services, by category of services:				
- medical services	not available	not available	not available	not available
- surgical services	not available	not available	not available	not available
- diagnostic services	not available	not available	not available	not available
- all insured physician services	$106,003,000	$108,270,000	$113,161,000	not available
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians:				
- general practitioners	$15.95	$15.61	$16.80	not available
- specialists	$27.93	$27.97	$29.36	not available
- all physicians	$21.25	$21.52	$23.04	not available
31. Average payment per service for insured fee-for-service physician services, by category of services:				
- medical services	not available	not available	not available	not available
- surgical services	not available	not available	not available	not available
- diagnostic services	not available	not available	not available	not available
- all insured physician services	$21.25	$21.52	$23.04	not available

[3] Includes number of salaried physicians, based on budgeted positions, and registered fee-for-service physicians as of March 31 of each year. Salaried physicians count may include some vacant positions at year end.

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year).	29	25	30	not available
33. Number of insured services provided by dentists.	11,000	10,000	10,000	not available
34. Total payments to dentists for insured surgical-dental services.	$335,000	$309,000	$374,000	not available
35. Average payment per service for insured surgical-dental services.	$30.20	$32.46	$38.34	not available

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in and outside Canada).[4]	168,000	175,000	165,000	not available
37. Total payments for out-of-province, insured physicians services (in and outside Canada).[4]	$4,440,000	$4,306,000	$4,435,000	not available
38. Average payment per service for out-of province, insured physician services (in and outside Canada).[4]	$26.49	$24.61	$26.90	not available

[4] Includes both in-patient and out-patient service.

Prince Edward Island

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
- acute care facilities	7	7	7	7
- chronic care facilities	2	2	2	2
Total facilities	9	9	9	9
2. Number of staffed beds in facilities providing insured hospital services, by category:				
- acute care beds	470	470	470	470
- chronic care beds	57	57	57	57
- rehabilitative beds	20	20	20	20
- day surgery beds.	19	19	19	19
Total staffed beds	566	566	566	566
3. Approved bed complements in facilities providing insured hospital services, by category:				
- acute care beds	470	470	470	470
- chronic care beds	57	57	57	57
- rehabilitative beds	20	20	20	20
- day surgery beds.	19	19	19	19
Total approved bed complement	566	566	566	566
4. Number of separations from facilities providing insured hospital services, by type of care:				
- acute care beds	18,047	18,626	18,644	17,796
- chronic care beds	not available	not available	not available	not available
- rehabilitative beds	336	347	377	360
- day surgery beds *(not available from CIHI)*	6,295	5,911	6,250	6,186
Total separations	24,678	24,884	25,271	24,342
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care:				
- acute care	8.2	8.1	7.9	8.4
- chronic care	not available	not available	not available	not available
- rehabilitative care.	18	19	19	18
6. Total payments to facilities providing insured hospital services, by type of facility:				
- acute care facilities	$95.1M[1]	$94.8M	$101.6M	$104.0M
- chronic care facilities				
- rehabilitative facilities				
- out-patient surgical facilities				
- out-patient diagnostic facilities				
- other facilities.				
Total payments to all facilities providing insured hospital services				

[1] "M" represents "millions".

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative care facilities.	$642.63	$628.35	$689.81	$695.72
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative facilities.	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facility: - acute care facilities - chronic care facilities - rehabilitative facilities.	not applicable not applicable not applicable	not applicable not applicable not applicable	not applicable not applicable not applicable	not applicable not applicable not applicable
10. Number of private health care facilities providing insured health services: - private surgical facilities - private diagnostic facilities Total	 0 0 0	 0 0 0	 0 0 0	 0 0 0
11. Number of insured health services provided at; - private surgical facilities - private diagnostic facilities Total	 0 0 0	 0 0 0	 0 0 0	 0 0 0
12. Total payments to: - private surgical facilities - private diagnostic facilities Total	 0 0 0	 0 0 0	 0 0 0	 0 0 0

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	1,893	1,904	2,279	1,812
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	11,478	13,341	16,457	14,428
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$11.9M	$11.3M	$12.3M	$10.6M
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$1.4M	$1.7M	$2.6M	$2.3M
17. Average payment for out-of-province, in-patient insured hospital services (in-Canada).	$6,286	$5,935	$5,397	$5,850
18. Average payment for out-of-province, out-patient hospital services (in-Canada).	$122	$127	$158	$160

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	35	48	27	21
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	157	211	102	106
21. Total payments for out-of-country, in-patient, insured hospital services.	$121,000	$119,400	$50,100	$53,800
22. Total payments for out-of-country, out-patient, insured hospital services.	$41,500	$76,600	$11,700	$21,700
23. Average payment for out-of-country, in-patient insured hospital services.	$3,457	$2,488	$1,856	$2,561
24. Average payment for out-of-country, out-patient hospital services.	$264	$363	$115	$205

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:[2]				
- general practitioners	92.3	97.4	97.8	98.6
- specialists	80.1	74.6	71.7	74.0
- all physicians.	172.4	172.0	169.5	172.6
26. Number of insured services provided, by category of physicians (fee-for-service):				
- general practitioners	838,527	834,740	869,320	848,816
- specialists	386,714	394,912	422,483	415,130
- all physicians.	1,225,141	1,229,652	1,291,803	1,263,946
27. Number of insured physician services provided by category of services:				
- medical services	132,979	141,594	158,836	154,930
- surgical services	139,338	138,667	146,186	144,947
- diagnostic services	114,397	114,651	117,461	115,253
- all insured physician services.	1,225,141	1,229,652	1,291,803	1,263,946
28. Total payments to (fee-for-service) physicians for insured services, by category of physicians:				
- general practitioners	$14.4M	$14.8M	$15.0M	$15.7M
- specialists	$15.3M	$15.6M	$16.2M	$17.1M
- all physicians.	$29.7M	$30.4M	$31.2M	$32.8M
29. Total payments to physicians for insured services, by category of services:				
- medical services	$5.6M	$5.9M	$6.2M	$6.6M
- surgical services	$8.0M	$8.0M	$8.3M	$8.8M
- diagnostic services	$1.7M	$1.7M	$1.7M	$1.7M
- all insured physician services.	$29.7M	$30.4M	$31.2M	$32.8M
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians:				
- general practitioners	$17	$18	$17	$18
- specialists	$40	$40	$38	$41
- all physicians	$24	$25	$24	$26
31. Average payment per service for insured physician services, by category of services:				
- medical services	$42	$42	$39	$43
- surgical services	$57	$58	$57	$61
- diagnostic services	$15	$15	$15	$15
- all insured physician services.	$24	$25	$24	$26

[2] The numbers presented represent full-time equivalent physicians (FTE'S).

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists. (i.e. dentist who received payments in the year)	1	1	2	2
33. Number of insured services provided by dentists.	418	411	400	176
34. Total payments to dentists for insured surgical-dental services.	$49,900	$50,200	$52,700	$37,600
35. Average payment per service for insured surgical-dental services.	$119	$122	$132	$214

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in-Canada).	57,904	58,667	56,192	56,084
37. Total payments for out-of-province, insured physician services.	$2.65M	$2.78M	$3.09M	$3.08M
38. Average payment per service for out-of-province, insured physician services.	$46	$47	$55	$55

Nova Scotia

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities[1]	34	34	34	34
– chronic care facilities				
– rehabilitative care facilities				
– out-patient diagnostic and surgical facilities				
– other facilities				
Total facilities	34	34	34	34
2. Number of staffed beds in facilities providing insured hospital services, by category of bed:				
– acute care beds				
– chronic care beds				
– rehabilitative care beds				
– day surgery beds				
Total staffed beds	3,375	3,226	3,233	3,125
3. Approved bed complements in facilities providing insured hospital services, by category of bed:				
– acute care beds	not applicable	not applicable	not applicable	not applicable
– chronic care beds	not applicable	not applicable	not applicable	not applicable
– rehabilitative care beds	not applicable	not applicable	not applicable	not applicable
– day surgery beds	not applicable	not applicable	not applicable	not applicable
Total approved bed complement	not applicable	not applicable	not applicable	not applicable
4. Number of separations from facilities providing insured hospital services, by type of care:				
– acute care beds	109,673	108,509	106,932	104,480
– chronic care beds				
– rehabilitative care beds	897	944	855	792
– alternate level of care				
– newborns	10,474	9,954	9,720	9,607
– surgical day care	77,433	86,016	89,069	93,701
Total separations	197,667	205,323	206,576	208,580
5. Average length of in-patient stay (number of days) in facilities providing insured hospital services, by type of care:				
– acute care facilities[2]	7.28	7.8	7.47	7.85
– chronic care facilities				
– rehabilitative care facilities	36.74	45.57	44.78	44.98

[1] Chronic and rehabilitation services are provided in acute care facilities.

[2] Excludes newborns.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services by type of facility:				
– acute care facilities	$645,026,000	$701,208,000	$795,946,000	$812,776,800
– chronic care facilities				
– rehabilitative care facilities				
– out-patient surgical facilities				
– out-patient diagnostic facilities				
– other facilities				
Total payments to all facilities providing insured hospital services	$645,026,000	$701,208,000	$795,946,000	$812,776,800
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:				
– acute care facilities	$435.85	$435.85	$391.55	$391.55
– chronic care facilities	not applicable	not applicable	not applicable	not applicable
– rehabilitative care facilities	not applicable	not applicable	not applicable	not applicable
8. Average per diem cost for out-patient care services by type of facility providing insured hospital services:				
– acute care facilities	not applicable	not applicable	not applicable	not applicable
– chronic care facilities	not applicable	not applicable	not applicable	not applicable
– rehabilitative care facilities	$89.00	$89.00	$110.00	$110.00
9. Average per diem cost for insured hospital services by type of facility:				
– acute care facilities	not applicable	not applicable	not applicable	not applicable
– chronic care facilities	not applicable	not applicable	not applicable	not applicable
– rehabilitative care facilities	$262.43	$262.43	$250.78	$250.78
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	1	1	1	1
– private diagnostic facilities	not applicable	not applicable	not applicable	not applicable
Total	1	1	1	1
11 Number of insured health services provided at:				
– private surgical facilities	not applicable	not applicable	not applicable	not applicable
– private diagnostic facilities	not applicable	not applicable	not applicable	not applicable
Total	not applicable	not applicable	not applicable	not applicable
12. Total payments to:				
– private surgical facilities	not applicable	not applicable	not applicable	not applicable
– private diagnostic facilities	not applicable	not applicable	not applicable	not applicable
Total	not applicable	not applicable	not applicable	not applicable

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	2,173	2,846	2,937	2,816
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	24,521	29,165	29,926	29,799
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$9,100,401	$9,435,789	$9,759,249	$9,704,639
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$2,294,099	$3,063,938	$3,472,464	$3,504,388
17. Average payment for out-of-province, in-patient insured hospital services (in-Canada).	$4,187.94	$3,315.46	$3,322.86	$3,446.25
18. Average payment for out-of-province, out-patient hospital services (in-Canada).	$93.56	$105.06	$116.04	$117.50

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	312	246	283	223
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	Not available	Not available	Not available	Not available
21. Total payments for out-of-country, in-patient, insured hospital services.	$1,003,664	$851,689	$859,642	$1,053,577
22. Total payments for out-of-country, out-patient, insured hospital services.	Not available	Not available	Not available	Not available
23. Average payment for out-of-country, in-patient insured hospital services.	$3,217	$3,202	$3,038	$4,725
24. Average payment for out-of-country, out-patient hospital services.	Not available	Not available	Not available	Not available

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:				
– general practitioners	not available	not available	not available	956
– specialists	not available	not available	not available	915
– all physicians	1,826	1,836	1,853	1,871
26. Number of insured services provided, by category of physician (fee-for-service):				
– general practitioners	not available	4,443,772	4,334,359	4,619,083
– specialists	not available	1,854,669	1,794,146	1,606,842
– all physicians	6,298,935	6,298,441	6,128,505	6,225,925
27. Number of insured physician services provided, by category of service:				
– medical services	not available	5,980,487	5,809,644	5,908,054
– surgical services	not available	317,854	320,861	317,871
– diagnostic services	not available	1,545,203	1,544,529	1,514,011
– all insured physician services	6,854,885	7,843,544	7,673,034	7,739,936
28. Total payments to (fee-for-service) physicians for insured services, by category of physician:				
– general practitioners	$94,476,324	$91,782,118	$91,620,190	$104,587,110
– specialists	$108,424,409	$115,725,195	$118,656,216	$112,250,617
– all physicians	$202,900,733	$207,507,313	$210,276,406	$216,837,726
29. Total payments to physicians for insured services, by category of service:				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services	$267,449,785	$296,138,155	$317,320,281	$350,091,235[3]
30. Average payment per service for insured (fee-for-service) physician services, by category of physician:				
– general practitioners	not available	$20.65	$21.14	$22.64
– specialists	not available	$62.40	$66.14	$69.86
– all physicians	$32.21	$32.95	$34.31	$34.83
31. Average payment per service for insured physician services, by category of service:				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services	$39.02	$37.76	$41.38	$45.23

[3] Estimate.

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year).	55	53	54	55[4]
33. Number of insured services provided by dentists.	14,525	15,549	16,909	17,525
34. Total payments to dentists for insured surgical-dental services.	$1,439,885	$1,515,311	$1,726,646	$1,467,485
35. Average payment per service for insured surgical-dental services.	$99.13	$97.45	$102.11	$83.74

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province physician services (in-Canada).	not available	not available	not available	not available
37. Total payments for out-of-province insured physician services.	$3,561,755	$4,394,519	$4,312,032	$4,441,830
38. Average payment per service for out-of-province insured physician services.	not available	not available	not available	not available

[4] Estimate.

New Brunswick

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities	31	31	31	31
– chronic care facilities	0	0	0	0
– rehabilitative care facilities	1	1	1	1
– out-patient diagnostic and surgical facilities	0	0	0	0
– other facilities	0	0	0	0
Total facilities	32	32	32	32
2. Number of staffed beds in facilities providing insured hospital services, by category of bed:				
– acute care beds	not available	not available	not available	not available
– chronic care beds	not applicable	not applicable	not applicable	not applicable
– rehabilitative care beds	not available	not available	not available	not available
– day surgery beds	not available	not available	not available	not available
Total staffed beds	not available	not available	not available	not available
3. Approved bed complements in facilities providing insured hospital services, by category of bed:				
– acute care beds	3,036	3,036	3,036	3,036
– chronic care beds	397	397	397	397
– rehabilitative care beds	20	20	20	20
– day surgery beds	0	0	0	0
Total approved bed complement	3,453	3,453	3,453	3,453
4. Number of separations from facilities providing insured hospital services, by type of care:				
– acute care beds	110,318	110,619	109,235	108,045
– chronic care beds	2,423	2,280	2,398	2,281
– rehabilitative care beds	406	457	411	444
– alternate level of care	231	246	307	308
– newborns	8,347	8,050	7,939	7,778
– surgical day care	45,175	44,597	42,962	46,287
Total separations	166,900	166,249	163,252	165,143
5. Average length of in-patient stay (number of days) in facilities providing insured hospital services, by type of care:				
– acute care facilities				
• acute care separations	6.3	6.4	6.6	6.6
• restorative/extended care separations	52.6	54.5	49.6	56.5
• rehabilitative care separations	44.2	46.6	56.2	52.3
– chronic care facilities	not applicable	not applicable	not applicable	not applicable
– rehabilitative care facilities	41.9	39.1	47.3	41.3

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services by type of facility:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
– out-patient surgical facilities	not available	not available	not available	not available
– out-patient diagnostic facilities	not available	not available	not available	not available
– other facilities	not available	not available	not available	not available
Total payments to all facilities providing insured hospital services	$641,045,782	$640,228,215	$684,869,764	not available
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
8. Average per diem cost for out-patient care services by type of facility providing insured hospital services:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facility:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	not applicable	not applicable	not applicable	not applicable
– private diagnostic facilities	not applicable	not applicable	not applicable	not applicable
Total	not applicable	not applicable	not applicable	not applicable
11 Number of insured health services provided at:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
12. Total payments to:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	481 pts/ 3,342 days	310 pts/ 2,154 days	337 pts/ 2,215 days	459 pts/ 3,320 days
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	983	2,502	3,013	3,374
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$2,815,749	$1,883,505	$2,113,634	$2,997,201
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$101,445	$268,440	$398,090	$435,404
17. Average payment for out-of-province, in-patient, insured hospital services (in-Canada).	$843	$874	$954	$903
18. Average payment for out-of-province, out-patient, hospital services (in-Canada).	$103	$107	$132	$129

Hospital Services Provided Out-of-Country				
Insured Hospital Services1996-1997	**1997-1998**	**1998-1999**	**1999-2000**	
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	19 pts/ 72 days	12 pts/ 73 days	9 pts/ 51 days	12 pts/ 340 days
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	110	32	18	62
21. Total payments for out-of-country, in-patient, insured hospital services.	$50,919	$16,736	$4,795	$87,865
22. Total payments for out-of-country, out-patient, insured hospital services.	$12,381	$5,227	$11,189	$7,528
23. Average payment for out-of-country, in-patient insured hospital services.	707	229	94	258
24. Average payment for out-of-country, out-patient hospital services.	111	163	622	121

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:				
– general practitioners	575	581	619	629
– specialists	678	682	709	721
– all physicians	1,253	1,263	1,328	1,350
26. Number of insured services provided, by category of physician (fee-for-service):				
– general practitioners	3,626,061	3,625,877	3,692,566	3,721,782
– specialists	2,423,736	2,479,186	2,507,588	2,612,744
– all physicians	6,049,797	6,105,063	6,244,229	6,334,526
27. Number of insured physicians services provided, by category of service:				
– medical services	684,943	686,896	729,803	739,911
– surgical services	805,335	827,458	828,626	852,725
– diagnostic services	933,458	964,832	993,234	1,020,108
– all insured physician services	6,049,797	6,105,063	6,244,229	6,334,526
28. Total payments to (fee-for-services) physicians for insured services, by category of physician:				
– general practitioners	$73,575,982	$74,575,504	$77,851,628	$77,958,130
– specialists	$96,165,584	$100,834,441	$101,620,362	$111,554,173
– all physicians	$169,741,567	$175,409,945	$179,471,990	$189,512,303
29. Total payments to physicians for insured services, by category of services:				
– medical services	$36,116,218	$37,548,393	$40,384,442	$41,795,791
– surgical services	$44,697,549	$46,574,724	$46,871,179	$48,732,272
– diagnostic services	$15,351,817	$16,711,324	$17,497,245	$21,026,109
– all insured physician services	$169,741,567	$175,409,945	$179,471,990	$189,512,203
30. Average payment per service for insured (fee-for-service) physician services, by category of physician:				
– general practitioners	$20.29	$20.57	$21.08	$20.95
– specialists	$39.68	$40.67	$40.53	$42.70
– all physicians	$28.06	$28.73	$28.74	$29.92
31. Average payment per service for insured physician services, by category of service:				
– medical services	$52.73	$54.66	$55.34	$56.49
– surgical services	$55.50	$56.29	$56.56	$57.15
– diagnostic services	$16.45	$17.32	$17.62	$20.61
– all insured physician services	$28.06	$28.73	$28.74	$29.92

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year).	12	14	17	12
33. Number insured services provided by dentists.	602	632	790	751
34. Total payments to dentists for insured surgical-dental services.	$96,683	$119,524	$132,517	$136,491
35. Average payment per service for insured surgical-dental services.	$161	$189	$168	$182

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province insured physician services (in-Canada).	132,873	153,230	140,375	137,950
37. Total payments for out-of-province insured physician services	$4,665,617	$6,186,476	$5,684,969	$6,050,729
38. Average payment per service for out-of-province insured physician services.	$35.11	$40.37	$40.50	$43.86

Ontario

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities	not available[1]	179	157	154
– chronic care facilities	not available[1]	20	22	21
– rehabilitative care facilities	not available[1]	6	5	4
– out-patient diagnostic and surgical facilities	not available[2]	not available[2]	not available[2]	not available[2]
– other facilities	not available[1]	4	4	3
Total facilities	not available[8]	not available[8]	not available[8]	not available[8]
2. Number of staffed beds in facilities providing insured hospital services, by category of bed:				
– acute care beds	26,367	24,505	23,872	24,254[3]
– extended care beds	8,678	8,149	7,787	7,505[4]
– rehabilitative care beds	1,875	1,815	1,822	1,975[4]
– day surgery beds	not available[5]	not available[5]	not available[5]	not available[5]
Total staffed beds	not available[8]	not available[8]	not available[8]	not available[8]
3. Approved bed complements in facilities providing insured hospital services, by category of bed:				
– acute care beds	not available[6]	not available[6]	not available[6]	not available[6]
– chronic care beds	not available[6]	not available[6]	not available[6]	not available[6]
– rehabilitative care beds	not available[6]	not available[6]	not available[6]	not available[6]
– day surgery beds	not available[6]	not available[6]	not available[6]	not available[6]
Total approved bed complement	not available[8]	not available[8]	not available[8]	not available[8]
4. Number of separations from facilities providing insured hospital services, by type of care:				
– acute care beds	1,074,967	1,041,004	1,131,333	1,007,464
– chronic care beds	17,321	18,426	17,165	18,943
– rehabilitative care beds	17,399	18,513	18,865	20,387
– alternate level of care				
– newborns				
– day surgery beds	782,503	876,164	870,935	not available[7]
Total separations	not available[8]	not available[8]	not available[8]	not available[8]
5. Average length of in-patient stay (number of days) in facilities providing insured hospital services, by type of care:				
– acute care facilities	6.27	6.21	5.98	not available[8]
– chronic care facilities	204.8	202.8	192.7	not available[8]
– rehabilitative care facilities	32.6	32.3	30.3	not available[8]

[1] Historical data no longer available.

[2] Ontario does not have facilities in these categories. These types of facilities are privately owned and any insured services provided are covered by the province.

[3] ADC (acute daily census) plus Psychiatric from PDST (planning decision support tool) and Psychiatric 2000.

[4] ADC.

[5] Day surgery beds are considered as "cases" whereas acute, chronic and rehabilitative beds are separations/admissions.

[6] Not available - there is no central repository of this data.

[7] Information has not been compiled. Will be available at a later date from PDST - Planning decision support tool.

[8] Information has not been compiled. Will be available at a later date from OHFS - Ontario Hospital Financial Statistics.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services by type of facility:[9]				
– acute care facilities	not available[9]	not available[9]	not available[9]	not available[9]
– chronic care facilities	not available[9]	not available[9]	not available[9]	not available[9]
– rehabilitative care facilities	not available[9]	not available[9]	not available[9]	not available[9]
– out-patient surgical facilities	not available[9]	not available[9]	not available[9]	not available[9]
– out-patient diagnostic facilities	not available[9]	not available[9]	not available[9]	not available[9]
– other facilities	not available[9]	not available[9]	not available[9]	not available[9]
Total payments to all facilities providing insured hospital services	$7.4 billion	$6.7 billion	$7.1 billion	$7.5 billion
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:[9]				
– acute care facilities	$626	$654	$691	not available[10]
– chronic care facilities	$253	$266	$274	not available[10]
– rehabilitative care facilities	$363	$369	$385	not available[10]
8. Average per diem cost for out-patient care services by type of facility providing insured hospital services:[11]				
– acute care facilities	not available[11]	not available[11]	not available[11]	not available[11]
– chronic care facilities	not available[11]	not available[11]	not available[11]	not available[11]
– rehabilitative care facilities	not available[11]	not available[11]	not available[11]	not available[11]
9. Average per diem cost for insured hospital services by type of facility:				
– acute care facilities	not available[12]	not available[12]	not available[12]	not available[12]
– chronic care facilities	not available[12]	not available[12]	not available[12]	not available[12]
– rehabilitative care facilities	not available[12]	not available[12]	not available[12]	not available[12]
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	not available[12]	not available[12]	not available[12]	not available[12]
– private diagnostic facilities	not available[12]	not available[12]	not available[12]	not available[12]
Total	not available[*]	not available[*]	not available[*]	not available[*]
11 Number of insured health services provided at:				
– private surgical facilities	not available[12]	not available[12]	not available[12]	not available[12]
– private diagnostic facilities	not available[12]	not available[12]	not available[12]	not available[12]
Total	not available[*]	not available[*]	not available[*]	not available[*]
12. Total payments to:				
– private surgical facilities	not available[12]	not available[12]	not available[12]	not available[12]
– private diagnostic facilities	not available[12]	not available[12]	not available[12]	not available[12]
Total	not available[*]	not available[*]	not available[*]	not available[*]

[9] a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with a minority of single patient type.
b) Separating by facility gives a small sample size for chronic and rehabilitative beds, thus distorting the amounts actually spent for chronic and rehabilitative beds.

[10] Information has not been compiled. Will be available at a later date from Ontario Case Cost Distribution Methodology.

[11] Outpatient by definition does not stay for 24 hours so the average out-patient cost per diem data cannot be provided:
a) Facilities in Ontario tend to be mixed; they report outpatient visits by patient type.
b) Also, separating by facility gives a small sample size for chronic and rehabilitative beds (see above facility count).
c) Mergers and amalgamations during this period also contribute some of the variability to the figures.
d) Reporting of visits in rehabilitative facilities does not at this time provide useable data because of the small number of rehabilitative facilities and reporting problems.

[12] Not available - The reliability of the data are questionable and are not supportable or reportable.

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	6,494	8,004	8,431	8,500 est.
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	80,263	102,504	104,398	105,000 est.
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$27.9M[13]	$36.2M	$32.8M	$36.0M est.
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$8.3M	$10.7M	$13.3M	$14.0M
17. Average payment for out-of-province, in-patient insured hospital services (in-Canada).	$4,307	$4,519	$3,890	$4,235 est.
18. Average payment for out-of-province, out-patient hospital services (in-Canada).	$102	$104	$127	$133

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient and out-patient, insured hospital services.	30,688	26,211	24,141	20,657
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	See above	See above	See above	See above
21. Total payments for out-of-country, in-patient and out-patient, insured hospital services.	$31.6M	$25.0M	$21.4M	$17.0M
22. Total payments for out-of-country, out-patient, insured hospital services.	See above	See above	See above	See above
23. Average payment for out-of-country, in-patient and out-patient insured hospital services.	$1,029.72	$953.80	$885.34	$821.24
24. Average payment for out-of-country, out-patient hospital services.	See above	See above	See above	See above

[13] "M" represents "millions".

In-Province Physician Services				
Insured Physician Services [14, 15]	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:[14 15]				
– general practitioners	10,475	10,319	10,221	10,227
– specialists	9,825	9,944	9,994	10,284
– all physicians	20,300	20,263	20,215	20,511
26. Number of insured services provided, by category of physician (fee-for-service):				
– general practitioners	82.0M	83.6M	80.4M	79.6M
– specialists	85.9M	90.8M	89.9M	91.4M
– all physicians	167.9M	174.4M	170.3M	171.0M
27. Number of insured physician services provided, by category of service:				
– medical services	84.1M	85.3M	84.2M	84.1M
– surgical services	21.4M	22.2M	21.6M	22.0M
– diagnostic services	62.4M	66.8M	64.4M	64.8M
– all insured physician services	167.9M	174.3M	170.2M	170.9M
28. Total payments to (fee-for-service) physicians for insured services, by category of physician:				
– general practitioners	$1,688.3M	$1,722.7M	$1,676.9M	$1,725.2M
– specialists	$2,443.5M	$2,618.6M	$2,587.2M	$2,699.2M
– all physicians	$4,131.8M	$4,341.3M	$4,264.1M	$4,424.4M
29. Total payments to physicians for insured services, by category of service:				
– medical services	$2,593.9M	$2,664.5M	$2,605.6M	$2,678.6M
– surgical services	$586.2M	$616.0M	$608.5M	$633.8M
– diagnostic services	$951.7M	$1,060.8M	$1,050.1M	$1,112.0M
– all insured physician services	$4,131.8M	$4,341.3M	$4,264.2M	$4,424.4M
30. Average payment per service for insured (fee-for-service) physician services, by category of physician:				
– general practitioners	$20.59	$20.61	$20.86	$21.67
– specialists	$28.45	$28.84	$28.78	$29.53
– all physicians	$24.61	$24.89	$25.05	$25.87
31. Average payment per service for insured physician services, by category of service:				
– medical services	$30.84	$31.24	$30.94	$31.84
– surgical services	$27.45	$27.72	$28.19	$28.78
– diagnostic services	$15.24	$15.87	$16.30	$17.15
– all insured physician services	$24.61	$24.90	$25.05	$25.87

[14] Numbers in the Annex are the number of physicians who bill through the FFS system. The Annex numbers are derived from the Ontario Statistical Reporting System. Not all physicians who are registered bill FFS. Number of physician services do not include laboratory services. Also, obstetrical care is included under medical services.

[15] Physician services include assistant and anaesthetist time based units, and the diagnostic portion includes both the professional and technical components counted separately.

In-Province Surgical-Dental Services				
Insured Physician Services[16]	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year).[16]	367	366	350	350
33. Number of insured services provided by dentists.	67,156	69,163	70,658	69,400
34. Total payments to dentists for insured surgical-dental services.	$7.8M	$7.9M	$7.9M	$8.1M
35. Average payment per service for insured surgical-dental services.	$116.15	$114.22	$111.80	$116.71

Out-of-Province Physician Services (In Canada)				
Insured Physician Services[14, 15]	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, in-patient and out-patient insured physician services (in-Canada).	399,005	428,329	433,396	450,000 est.
37. Total payments for out-of-province, in-patient and out-patient insured physician services.	$12.9M	$12.8M	$13.3M	$14.0M est.
38. Average payment per service for out-of-province, insured physician services.	$32.43	$29.90	$30.59	$31.11 est.

* Totals cannot be provided, as some data are not available.

Source for all insured physician services data: Ontario Statistical Reporting System (OSRS), April 1996 - March 1999.

[16] Number of participating dentists is 350, but over 700 are registered on the Corporate Provider Database.

Manitoba

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities (Provincial)	75	75	75	75
– acute care facilities (Federal)	20	20	20	20
– chronic care/rehabilitative facilities	4	4	4	4
Total facilities	99	99	99	99
2. Number of "set-up" beds[1] and cribs in facilities providing insured hospital services, by category:				
– acute care beds (Provincial Facilities)	4,533	4,464	4,341	4,299
– acute care beds (Federal Facilities)	95	95	95	95
– chronic care/rehabilitative beds	559	392	402	402
– day surgery	not available	not available	not available	not available
Total staffed beds	5,187	4,951	4,838	4,796
3. Approved bed complements in facilities providing insured hospital services, by category:				
– acute care beds (Provincial Facilities)	4,533	4,464	4,341	4,299
– acute care beds (Federal Facilities)	95	95	95	95
– chronic care/rehabilitative beds	559	392	402	402
Total approved bed complement	5,187	4,951	4,838	4,796
4. Number of separations from facilities providing insured hospital services, by type of care:				
– acute care beds (Provincial Facilities)	135,634	132,808	132,912	129,222
– acute care beds (Federal Facilities)	3,829	4,123	3,587	3,428
– chronic care/rehabilitative beds	1,640	1,746	1,757	1,876
– newborns	15,838	14,784	14,814	14,807
– surgical day care	99,571	107,418	111,931	115,136
Total separations	141,103	138,677	138,256	134,526
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care:				
– acute care beds (Provincial Facilities)	9.6	9.5	9.7	9.9
– acute care beds (Federal Facilities)	1.9	1.7	1.8	1.8
– chronic care/rehabilitative beds	103.6	118	74.3	69.0

[1] The number of beds that are set up as of March 31 for patient accommodation by a hospital.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services, by type of facility:				
– acute care facilities[2]	$909,637,278	$906,268,524	$884,687,936	$941,898,371
– chronic care/rehab facilities[3]	$52,798,545	$56,443,179	$59,519,958	$64,155,009
Total payments to facilities providing insured hospital services	$962,435,823	$962,711,703	$944,207,894	$1,006,053,380
7. Average per diem cost for in-patient care services by type of facilities providing insured hospital services:				
– acute care facilities	$661.62	$656.10	not available	not available
– chronic care/rehab care facilities	$279.47	$286.64	not available	not available
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services:				
– acute care facilities	not available	not available	not available	not available
– chronic care/rehab care facilities	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facility:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative facilities	not available	not available	not available	not available
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
11. Number of insured health provided at:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
12. Total payments to:				
– private surgical facilities	not available	not available	not available	$2,162,059
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available

[2] Reported numbers are on an accrual basis (expenses are charged to the period in which the goods were received or services were provided regardless of when the payment was made) and include total payments to facilities providing insured services net of reciprocal recoveries, as per Manitoba Health Services Insurance Plan financials.

[3] Reported numbers are on an cash basis (expenses are charged to the period (fiscal year) according to when the payments were made regardless of when the goods were received or the services were provided). They include Deer Lodge Centre, Riverview Health Centre, Manitoba Adolescent Treatment Centre and Hartney Rehabilitation and Chronic Care Hospital.

Hospital Services Provided Out-of-Province (in-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of cases paid for out-of-province, in-patient, insured hospital services (in-Canada).	3,174	3,419	3,307	2,571
14. Total number of cases paid for out-of-province, out-patient, insured hospital services (in-Canada).	24,779	28,422	28,007	21,570
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$12,506,685	$14,156,175	$11,292,528	$8,655,520
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$2,321,046	$2,947,701	$3,451,891	$2,694,973
17. Average payment for out-of-province, in-patient, insured hospital services (in-Canada).	$3,940.35	$4,140.44	$3,414.73	$3,366.60
18. Average payment for out-of-province, out-patient, hospital services (in-Canada).	$93.67	$103.71	$123.25	$124.94

Hospital Services Provided Out of Country[4]				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of cases paid for out-of-country, in-patient, insured hospital services.	530	614	588	565
20. Total number of cases paid for out-of-country, out-patient, insured hospital services.	5,810	6,331	5,782	6,053
21. Total payments for out-of-country, in-patient, insured hospital services.	$854,120	$991,294	$1,058,815	$1,028,127
22. Total payments for out-of-country, out-patient, insured hospital services.	$611,162	$658,890	$690,877	$905,479
23. Average payment for out-of-country, in-patient insured hospital services.	$1,611.55	$1,614.49	$1,800.71	$1,819.69
24. Average payment for out-of-country, out-patient hospital services.	$105.19	$104.07	$119.49	$149.59

[4] Reported numbers are on a cash basis and do not include foreign exchange on US transactions

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:				
– general practitioners	970	935	900	not available
– specialists	912	931	938	not available
– all physicians.	1,882	1,866	1,838	2,036
26. Number of insured services provided, by category of physicians (fee-for-service):				
– general practitioners	5,726,851	5,741,645	5,859,568	5,931,022
– specialists	6,712,187	7,281,386	7,698,155	8,147,749
– all physicians.	12,439,038	13,023,031	13,557,723	14,078,771
27. Number of insured physicians services provided, by category of service:				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services.	not available	not available	not available	not available
28. Total payments to(fee-for-services) physicians for insured services, by category of physicians:				
– general practitioners	$99,387,716	$99,489,900	$103,068,422	$114,868,500
– specialists	$146,956,655	$153,336,002	$165,946,999	$178,359,476
– all physicians.	$246,344,371	$252,825,902	$269,015,421	$293,227,976
29. Total payments to alternate funding physicians (by category of physician or service is not available)[5]	$61,546,400	$98,995,700	$107,484,800	$123,647,200
Total payments to all physicians (fee-for-service and alternate funding)	$307,890,771	$351,821,602	$376,500,221	$416,875,176
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians:[6]				
– general practitioners	$17.35	$17.33	$17.59	$19.37
– specialists	$21.89	$21.06	$21.56	$21.89
– all physicians	$19.80	$19.41	$19.84	$20.83
31. Average payment per service for insured physician services, by category of services:				
– medical services	not available	not available	not available	not available
– surgical service	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services	not available	not available	not available	not available

[5] These amounts are on an accrual basis.

[6] These amounts are on a cash basis.

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists: (i.e. dentists who received payments in the year)	65	94	102	105
33. Number insured services provided by dentists.	2,681	2,953	2,925	3,318
34. Total payments to dentists for insured surgical-dental services.	$496,505	$539,940	$589,378	$590,125
35. Average payment per service for insured surgical-dental services.	$185.19	$182.84	$201.50	$177.86

Out-of-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in-Canada).	222,601	217,733	206,521	183,497
37. Total payments for out-of-province, insured physician services	$6,267,296	$6,245,462	$6,121,559	$5,568,205
38. Average payment per service for out-of-province, insured physician services.	$28.15	$28.68	$29.64	$30.34

- All payment information is based on date of payment.
- As some amounts are on a cash basis and some are on an accrual basis, there may be discrepancies between the amounts reported here and the amounts contained in the Annual Report.

Saskatchewan

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities	75	73	71	71
– rehabilitative facilities	1	1	1	1
Total facilities	76	74	72	72
2. Number of staffed beds in facilities providing insured hospital services, by category:[1]				
– acute care beds	3,282	3,117	3,078	2,944
– psychiatric beds (short-term)	228	228	248	183
– rehabilitative beds (Rehab & acute hospital)	not available	152	152	90
– rehabilitative beds in Special care homes	not available	not available	not available	not available
Total staffed beds	3,510	3,497	3,478	3,217
3. Approved bed complements in facilities providing insured hospital services, by category:[2]				
– acute care beds	not applicable	not applicable	not applicable	not applicable
– chronic care beds	not applicable	not applicable	not applicable	not applicable
– rehabilitative care beds	not applicable	not applicable	not applicable	not applicable
– day surgery beds	not applicable	not applicable	not applicable	not applicable
Total approved bed complement	not applicable	not applicable	not applicable	not applicable
4. Number of separations from facilities providing insured hospital services, by type of care:[3]				
– acute care separations	148,740	146,537	143,604	134,000[4]
– psychiatric separations	4,106	3,988	3,309	4,065 (est)
– rehabilitation separations	1,401	1,338	1,058	927
Total separations	154,247	151,863	147,971	138,992
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care:[5]				
- acute care facilities	5.7	5.7	5.8	5.7[6]
- psychiatric care facilities	16.3	16.5	15.4	15.8 (est)
- rehabilitation facilities	32.4	30.9	30.5	34.7

[1] Excludes long term care beds in hospital.

[2] Not Applicable - The Department does not approve bed numbers. Health Districts are responsible for deciding the number of beds they operate.

[3] Excludes psychiatric and long term care separations from hospital.
Note that there was a province-wide nursing strike in April 1999.

[4] 1999-2000 number is an estimate based on preliminary data.

[5] Excludes psychiatric and long term care separations from hospitals.

[6] 1999-2000 length of stay is an estimate based on preliminary data.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services, by type of facility:[7] Funding is provided to health districts and not to facilities (see description in text portion of submission)				
- institutional acute care funding pool (acute care facilities)	$522,036,613	$584,582,800	$565,682,800	$619,538,151
- rehabilitative services.	$34,822,774	$35,115,992	$35,437,299	$36,824,546
7. Average per diem cost for in-patient care services by type of facilities providing insured hospital services:				
– acute care facilities	not available	not available	not available	$522 (est)
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facility	not available	not available	not available	not available
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services:				
- acute care facilities	not available	not available	not available	not available
- chronic care facilities	not available	not available	not available	not available
- rehabilitative care facilities	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facility:				
- acute care facilities	not available	not available	not available	not available
- chronic care facilities	not available	not available	not available	not available
- rehabilitative care facilities	not available	not available	not available	not available
10. Number of private facilities providing insured health services:				
– private surgical facilities	0	0	0	0
– private diagnostic facilities	0	0	0	0
Total	0	0	0	0
11. Number of insured health services provided at: private surgical facilities				
– private surgical facilities	0	0	0	0
– private diagnostic facilities	0	0	0	0
Total	0	0	0	0
12. Total payments to:				
– private surgical facilities	0	0	0	0
– private diagnostic facilities	0	0	0	0
Total	0	0	0	0

[7] Rehabilitation services include in-patient and out-patient, home based, community therapy, and physical therapy contracts.

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	4,788	4,868	4,688	5,019
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	35,493	38,279	41,375	44,327
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$22,415,100	$23,988,792	$18,973,762	$19,911,192
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$3,958,900	$4,194,100	$5,698,800	$5,939,300
17. Average payment per claim for out-of-province, in-patient, insured hospital services (in-Canada).	$4,682	$4,928	$4,047	$3,967
18. Average payment per claim for out-of-province, out-patient, hospital services (in-Canada).	$112	$110	$138	$134

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	337	317	273	382
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	1,574	1,695	1,252	1,201
21. Total payments for out-of-country, in-patient, insured hospital services.	$291,800	$710,800	$1,193,449	$2,484,961[8]
22. Total payments for out-of-country, out-patient, insured hospital services.	$128,900	$228,968	$151,558	$348,379
23. Average payment for out-of-country, in-patient insured hospital services.	$866	$2 242	$4,372	$6,505
24. Average payment for out-of-country, out-patient insured hospital services.	$82	$135	$121	$290

[8] Note that there was a province-wide nursing strike in April 1999.

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating (registered) physicians:				
– general practitioners	860	865	907	940
– specialists	583	592	595	610
– all physicians	1,443	1,457	1,502	1,550
26. Number of insured services provided, by category of physicians (fee-for-service 000's):				
– general practitioners	6,868	6,595	6,743	6,786
– specialists	3,122	3,069	3,127	3,163
– all physicians	9,990	9,664	9,870	9,949
27. Number of insured physicians services provided, by category of service ($000s):				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services	9,990	9,664	9,870	9,949
28. Total payments to (fee-for-services) physicians for insured services, by category of physicians ($000s):				
– general practitioners	$122,511	$119,002	$128,785	$133,043
– specialists	$118,531	$117,667	$122,466	$125,735
– all physicians	$240,646	$236,669	$251,251	$258,778
29. Total payments to physicians for insured services, by category of services ($000s):				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services[9]	$293,358	$307,786	$326,325	$334,104
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians:				
– general practitioners	$17.84	$18.04	$19.10	$19.61
– specialists	$37.84	$38.34	$39.16	$39.75
– all physicians	$24.09	$24.49	$25.46	$26.01
31. Average payment per service for insured physician services, by category of services:				
– medical services	not available	not available	not available	not available
– surgical services	not available	not available	not available	not available
– diagnostic services	not available	not available	not available	not available
– all insured physician services	not available	not available	not available	not available

[9] Includes all fee-for-service and salary/contract payments.

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentist (i.e. dentists who received payments in the year)	126	119	113	97
33. Number of insured services provided by dentist.	18,600	18,700	18,500	18,100
34. Total payments to dentists for insured surgical-dental services.	$1,290,700	$1,287,000	$1,271,700	$1,309,300
35. Average payment for insured surgical-dental services.	$69.39	$68.82	$68.74	$72.34

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in-Canada).	327,446	370,148	382,888	400,807
37. Total payments for out-of-province, insured physician services $000.	$10,049,574	$11,145,782	$11,411,851	$13,121,491
38. Average payment per service for out-of-province, in-patient insured physician services.	$30.69	$30.11	$29.80	$32.74

Alberta

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
- acute care facilities	101	101	101	101
- chronic care facilities	104	104	104	104
- rehabilitative facilities	1	1	1	1
- out-patient diagnostic facilities	not applicable	not applicable	not applicable	not applicable
- other facilities - community centres	0	0	0	3
Total facilities	206	206	206	209
2. Number of staffed beds in facilities providing insured hospital services, by category of bed:				
- acute care beds	6,176	6,305	6,360	6,275
- chronic care beds	6,179	6,179	6,404	6,179
- rehabilitative care beds	240	240	240	240
- day surgery beds	not applicable	not applicable	not applicable	not applicable
Total staffed bed	12,595	12,724	12,823	12,694
3. Approved bed complements in facilities providing insured hospital services, by category of bed:				
- acute care beds	9,788	9,788	9,788	9,788
- chronic care beds	6,114	6,114	6,114	6,114
- rehabilitative care beds	240	240	240	240
- day surgery beds	not applicable	not applicable	not applicable	not applicable
Total approved bed complement	16,142	16,142	16,142	16,142
4. Number of separations from facilities providing insured hospital services, by type of care:				
- acute care beds	not available	not available	not available	not available
- chronic care beds	not available	not available	not available	not available
- rehabilitative care beds	not available	not available	not available	not available
- alternate level of care	not available	not available	not available	not available
- newborns	not available	not available	not available	not available
- surgical day care.	not available	not available	not available	not available
Total separations	335,665	334,869	346,092	not available
5. Average length of in-patient stay (number of days) in facilities providing insured hospital services, by type of care: (includes newborns)				
- acute care facilities	not available	not available	not available	not available
- chronic care facilities	not available	not available	not available	not available
- rehabilitative care facilities	not available	not available	not available	not available
Total facilities	6.7	6.9	7.1	not available
6. Total payments to facilities providing insured hospital services, by type of facility:				
- acute care facilities	not applicable	not applicable	not applicable	not applicable
- chronic care facilities	not applicable	not applicable	not applicable	not applicable
- rehabilitative facilities	not applicable	not applicable	not applicable	not applicable
- out-patient surgical facilities	not applicable	not applicable	not applicable	not applicable
- out-patient diagnostic facilities	not applicable	not applicable	not applicable	not applicable
- other facilities	not applicable	not applicable	not applicable	not applicable
Total payments to all facilities providing insured hospital services	not applicable	not applicable	not applicable	not applicable

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:				
- acute care facilities	not applicable	not applicable	not applicable	not applicable
- chronic care facilities	not applicable	not applicable	not applicable	not applicable
- rehabilitative care facilities	not applicable	not applicable	not applicable	not applicable
8. Average per diem cost for out-patient care services by type of facility providing insured hospital services:				
- acute care facilities	not applicable	not applicable	not applicable	not applicable
- chronic care facilities	not applicable	not applicable	not applicable	not applicable
- rehabilitative care facilities	not applicable	not applicable	not applicable	not applicable
9. Average per diem cost for insured hospital services by type of facility:				
- acute care facilities	not applicable	not applicable	not applicable	not applicable
- chronic care facilities	not applicable	not applicable	not applicable	not applicable
- rehabilitative care facilities	not applicable	not applicable	not applicable	not applicable
10 Number of private health care facilities providing insured health services:				
- private surgical facilities	not available	not available	not available	not available
- private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
11. Number of insured health services provided at:				
- private surgical facilities	not available	not available	not available	not available
- private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
12. Total payments to:				
- private surgical facilities	not available	not available	not available	not available
- private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of- province, in-patient, insured hospital services (in-Canada).	4,565	4,656	4,714	4,820
14. Total number of claims paid for out-of- province, out-patient, insured hospital services (in-Canada).	55,477	56,408	57,574	59,443
15. Total payments for out-of-province, in-patient, insured hospital claims (in-Canada).	$16,065,099	$14,699,049	$13,269,781	$13,632,730
16. Total payments for out-of-province, out-patient, insured hospital claims (in-Canada).	$5,170,997	$5,287,271	$6,706,065	$6,920,702
17. Average payment for out-of-province, in-patient insured hospital claims (in-Canada).	$3,519.19	$3,157.01	$2,814.97	$2,828.37
18. Average payment for out-of-province, out-patient hospital claims (in-Canada).	$93.21	$93.73	$116.48	$116.43

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	9,148	8,311	7,680	6,817
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	234	200	101	128
21. Total payments for out-of-country, in-patient, insured hospital claims.	$725,916	$658,847	$597,690	$528,742
22. Total payments for out-of-country, out-patient, insured hospital claims.	$63,175	$53,457	$34,695	$34,791
23. Average payment for out-of-country, in-patient insured hospital claims.	$79.35	$79.27	$77.82	$77.56
24. Average payment for out-of-country, out-patient insured hospital claims.	$269.98	$267.28	$343.51	$271.81

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:				
- general practitioners	2,395	2,365	2,464	2,545
- specialists	1,833	1,903	1,978	2,096
- all physicians	4,228	4,268	4,442	4,841
26 Number of insured services provided, by category of physician (fee-for-service):				
- general practitioners	13,947,484	14,377,354	14,974,783	15,543,092
- specialists	9,291,690	9,844,887	10,392,632	10,798,883
- all physicians	23,239,174	24,222,241	25,367,415	26,341,975
27. Number of insured physician services provided, by category of service (based on specialty of the physician):				
- medical services(medical specialists)	19,760,427	20,548,109	21,517,182	22,359,160
- surgical services(surgical specialists)	2,222,103	2,263,615	2,288,284	2,345,494
- diagnostic services (laboratory and x-ray specialists)	1,256,644	1,410,517	1,561,949	1,637,321
- all insured physician services	23,239,174	24,222,241	25,367,415	26,341,975
28. Total payments to (fee-for-service) physicians for insured service, by category of physician:				
- general practitioners	$346,643,285	$357,611,870	$383,842,634	$410,502,506
- specialists	$399,772,398	$427,232,284	$464,270,463	$493,040,446
- all physicians	$746,415,686	$784,844,154	$848,113,097	$903,542,952
29. Total payments to physicians for insured services, by category of service (based on specialty of the physician):				
- medical services(medical specialists)	$537,506,075	$559,406,868	$603,212,295	$644,369,533
- surgical services(surgical specialists)	$147,629,569	$152,888,255	$161,168,036	$170,444,638
- diagnostic services+ (laboratory and x-ray specialists)	$61,280,042	$72,549,031	$83,732,766	$88,728,781
- all insured physician services	$746,415,686	$784,844,154	$848,113,097	$903,542,952
30. Average payment per service for insured (fee-for-service) physician services, by category of physician:				
- general practitioners	$24.85	$24.87	$25.63	$26.41
- specialists	$43.02	$43.40	$44.67	$45.66
- all physicians	$32.12	$32.40	$33.43	$34.30
31. Average payment per service for insured physician services, by category of services (based on specialty of the physician):				
- medical services(medical specialists)	$27.20	$27.22	$28.03	$28.82
- surgical services (surgical specialists)	$66.44	$67.54	$70.43	$72.67
- diagnostic services (laboratory & x-ray specialists)	$48.76	$51.43	$53.61	$54.19
- all insured physician services	$32.12	$32.40	$33.43	$34.30

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year)	241	230	232	250
33. Number of insured services provided by dentists	9,063	10,648	11,920	14,292
34. Total payments to dentists for insured surgical-dental services	$1,571,065	$1,691,797	$1,853,322	$2,092,003
35. Average payment per service for insured surgical-dental services	$173.35	$158.88	$155.48	$146.38

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in-Canada).	355,985	348,480	359,653	380,635
37. Total payments for out-of-province, insured physician services.	$10,412,565	$10,092,203	$9,983,110	$11,397,620
38. Average payment per services for out-of-province, insured physician services.	$29.25	$28.96	$27.76	$29.94

British Columbia

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000[1]**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities	93	93	94	94
– chronic care facilities	17	17	17	17
– rehabilitative care facilities	3	3	3	3
– out-patient diagnostic and surgical facilities[2]	25	25	25	25
– other facilities[3]	1	1		
Total facilities	139	139	139	139
2. Number of staffed beds in facilities providing insured hospital services, by category[4]:				
– acute care beds	not available	not available	not available	not available
– chronic care beds[5]	not available	not available	not available	not available
– rehabilitative care beds	not available	not available	not available	not available
– day surgery beds.	not available	not available	not available	not available
Total staffed beds	not available	not available	not available	not available
3. Approved bed complements in facilities providing insured hospital services, by category:				
– acute care beds	8,991	8,559	8,559	8,533
– chronic care beds	8,542	8,628	8,628	8,733
– rehabilitative care beds[6].	551	517	517	468
Total approved bed compliment	18,084	17,704	17,704	17,734
4. Number of separations from facilities providing insured hospital services, by type of care:				
– acute care beds	345,523	367,465	376,369	374,246
– chronic care beds	7,805	9,072	9,016	7,456
– rehabilitative care beds	2,612	2,409	2,565	2,959
– alternate level of care[7]	5,365	3,589	2,999	3,336
– newborns	35,559	35,162	34,124	38,863
– surgical day care	295,117	289,951	274,295	293,530
Total separations	691,981	707,648	699,368	720,390

[1] Projections have been made where data are incomplete.
[2] Outpatient diagnostic and surgical facilities include 6 Red Cross outposts.
[3] Federal hospital (Canadian Forces Station Hospital Masset) transferred to regional Health Authority in 1998-99.
[4] Data for staffed beds are not available.
[5] Chronic care beds include beds in free standing extended care facilities as well as those beds designated extended care in acute care facilities.
[6] Rehabilitation beds include beds in free standing rehabilitation facilities as well as those beds designated for rehabilitation care in acute care facilities.
[7] Alternate level of care: a patient occupies an acute care bed, but has been assessed as requiring another level of care, such as residential care or home care.

In-Province Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000[8]**
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care:				
– acute care facilities	5.62	5.71	5.42	5.32
– chronic care facilities	350.96	332.99	214.77	279.35
– rehabilitative care facilities	33.48	32.21	28.92	29.84
– alternate level of care facilities	30.78	33.70	29.03	31.84
– newborn facilities	2.92	2.67	2.18	2.28
6. Total payments to facilities providing insured hospital services (000s)[9]:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
Total payments to all facilities to providing insured hospital services	$2,722,833	$2,956,260	not available[10]	not available
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services[11]:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
9. Average per diem cost for insured hospital services by type of facilities:				
– acute care facilities	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
11. Number of insured health services provided at:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available
12. Total payments to:				
– private surgical facilities	not available	not available	not available	not available
– private diagnostic facilities	not available	not available	not available	not available
Total	not available	not available	not available	not available

[8] Projections have been made where data are incomplete.

[9] Data cannot be broken down by facility type as services are funded on a global basis.

[10] Funds are no longer designated by the Ministry to facilities. Global funding is provided to health authorities with responsibilities for a continuum of health services ranging from health promotion and disease and injury prevention to facility based care.

[11] Data are not collected by in-patient and out-patient categories.

Hospital Services Provided Out-of-Province (In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000[12]**
13. Total number of claims paid for out-of-province, in-patient, insured hospital services (in-Canada).	7,225	7,383	7,994	7,231[13]
14. Total number of claims paid for out-of-province, out-patient, insured hospital services (in-Canada).	62,604	68,146	73,807	70,070
15. Total payments for out-of-province, in-patient, insured hospital services (in-Canada).	$37,483,341	$35,898,630	$35,830,522	$34,477,406
16. Total payments for out-of-province, out-patient, insured hospital services (in-Canada).	$6,145,727	$7,441,321	$9,075,191	$9,585,916
17. Average payment for out-of-province, in-patient insured hospital services (in-Canada).	$5,188	$4,862	$4,482	$4,768
18. Average payment for out-of-province, out-patient hospital services (in-Canada).	$98	$109	$123	$137

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	2,946	2,888	2,793	2,494
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	340	431	435	324
21. Total payments for out-of-country, in-patient, insured hospital services.	$2,251,755	$3,073,453	$3,492,437	$5,375,289
22. Total payments for out-of-country, out-patient, insured hospital services.	$77,502	$109,347	$100,863	$65,137
23. Average payment for out-of-country, in-patient insured hospital services.	$764	$1,064	$1,250	$2,155
24. Average payment for out-of-country, out-patient hospital services.	$228	$254	$232	$201

[12] Projections have been made where data are incomplete.
[13] Claims are still being received (12 month time limit to bill).

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:[14]				
– general practitioners	4,154	4,248	4,269	4,276
– specialists[15]	3,116	3,181	3,232	3,269
– all physicians	7,270	7,429	7,501	7,545
26. Number of insured services provided, by category of physicians (fee-for-service):				
– general practitioners	22,197,196	22,378,959	21,903,525	22,875,620
– specialists	28,828,096	29,424,394	29,860,276	32,697,836
– all physicians	51,025,292	51,813,353	51,763,801	55,573,456
27. Number of insured physician services provided, by category of services:				
– medical services[16]	23,535,944	24,309,601	24,012,366	25,065,926
– surgical services[17]	5,601,151	4,209,195	4,163,434	4,426,656
– diagnostic services[18]	21,888,197	23,294,557	23,588,001	26,080,874
– all insured physician services	51,025,292	51,813,353	51,763,801	55,573,456
28. Total payments to (fee-for-service) physicians for insured services, by category of physicians[19]:				
– general practitioners	$613,317,385	$614,713,789	$626,992,277	$654,305,224
– specialists	$817,739,525	$831,174,498	$845,235,143	$928,642,083
– all physicians	$1,431,056,910	$1,445,888,287	$1,472,227,420	$1,582,947,307
29. Total payments to physicians for insured services, by category of services:				
– medical services	$834,731,808	$850,453,217	$874,004,742	$920,552,743
– surgical services	$230,651,787	$231,507,497	$229,196,329	$250,267,000
– diagnostic services	$365,673,314	$363,927,573	$369,026,348	$412,127,564
– all insured physician services	$1,431,056,909	$1,445,888,287	$1,472,227,419	$1,582,947,307

[14] Participating physicians are defined as British Columbia physicians receiving insured fee-for-service payments of >$1.00 from the province of British Columbia for one or more paid services in each fiscal year, 1996-1997, 1997-1998, 1998-1999, and 1999-2000.

[15] The number of specialists is the number of physicians practising in the following specialties by date of service year and paid to current (August 1, 2000): dermatology, neurology, psychiatry, neuropsychology, obstetrics and gynecology, ophthalmology, otolaryngology, general surgery, neurosurgery, orthopedics, plastic surgery, cardio and thoracic surgery, urology, paediatrics, internal medicine, radiology, pathology, anaesthesia, paediatric cardiology, physical medicine and rehabilitation, public health, occupational medicine, geriatric medicine, emergency medicine, medical microbiology, nuclear medicine, rheumatology, clinical immunization and allergy, medical genetics, and vascular surgery.

[16] Medical services consist of the following types of services: regional examinations, consultations, complete examinations, counselling, home visits, emergency visits, institutional visits, dialysis/transfusions, general services and therapeutic radiation.

[17] Surgical services consist of the following types of services: anaesthesia, cardiovascular, obstetrics, minor and non-minor surgeries.

[18] Diagnostic services consist of the following types of services: diagnostic ophthalmology, diagnostic radiology, diagnostic ultrasound, nuclear medicine, pathology, pulmonary function, electro-diagnosis, and procedural cardiology.

[19] Total payments, i.e., expenditures, include paid amount and Northern and Isolation Allowance (NIA), and proration. Expenditure figures exclude reciprocals, out-of-province payments, interest, tray fees; late claims from previous fiscal years of service, manual expenditures, claims-in-process, ICBC and Workers' Compensation Board fee-for-service claims, and claims referred by midwives.

In-Province Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians[20]:				
– general practitioners	$27.60	$27.40	$28.60	$28.60
– specialists	$28.30	$28.20	$28.30	$28.40
– all physicians	$28.00	$27.90	$28.44	$28.48
31. Average payment per service for insured physician services, by category of services[21]:				
– medical services	$35.47	$34.98	$36.40	$36.72
– surgical services	$41.18	$55.00	$55.04	$56.53
– diagnostic services	$16.70	$15.62	$15.64	$15.80
– all insured physician services	$28.00	$27.90	$28.44	$28.48

In-Province Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year)[22]	284	289	280	265
33. Number of insured services provided by dentists.	53,130	53,163	51,096	54,507
34. Total payments to dentists for insured surgical-dental services.	$5,663,597	$5,818,127	$5,474,563	$5,854,368
35. Average payment per service for insured surgical-dental services[23].	$106.60	$109.43	$107.14	$107.40

Out-of-Province Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-province, insured physician services (in-Canada).	477,236	461,571	438,186	446,232
37. Total payments for out-of-province, insured physician services.	$13,844,944	$13,849,906	$13,495,893	$14,134,689
38. Average payment per service for out-of-province, insured physician services.	$29	$30	$31	$32

[20] The average payment for insured services is calculated by dividing the total amount of expenditures by the number of services performed by general practitioners, specialists, and all physicians.

[21] The average payment for insured services is calculated by dividing the total amount of expenditures by the number of services performed by the category of services.

[22] Participating practitioners include orthodontists, oral and dental surgeons.

[23] The average payment for insured surgical dental services is calculated by dividing the total expenditures by the number of surgical-dental services provided.

Yukon

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes):				
– acute care facilities	1	1	1	1
– cottage hospital	1	1	1	1
– chronic care facilities				
– rehabilitative care facilities				
– out-patient diagnostic and surgical facilities				
– other facilities[1]	15	15	15	15
Total facilities	17	17	17	17
2. Number of staffed beds in facilities providing insured hospital services, by category of bed:				
– acute care beds	70	59	59	61
– chronic care beds				
– rehabilitative care beds				
– day surgery beds	10	10	10	10
Total staffed beds	80	69	69	71
3. Approved bed complements in facilities providing insured hospital services, by category of bed:				
– acute care beds	70	67	67	67
– chronic care beds				
– rehabilitative care beds				
– day surgery beds	10	10	10	10
Total approved bed complement	80	77	77	77
4. Number of admissions to facilities providing insured hospital services, by type of care:				
– acute care beds	3,464	3,306	3,125	2,914
– cottage hospital	469	414	384	427
– chronic care beds				
– rehabilitative care beds				
– day surgery beds	1,646	1,524	1,606	1,624
Total admissions	5,579	5,244	5,115	4,965
5. Average length of in-patient stay (number of days) in facilities providing insured hospital services, by type of care:				
– acute care facilities	4.1	4.0	4.4	4.8
– cottage hospital	3.4	2.8	3.1	2.5
– chronic care facilities	not applicable	not applicable	not applicable	not applicable
– rehabilitative care facilities	not applicable	not applicable	not applicable	not applicable

[1] Health Centres and Nursing Stations

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
6. Total payments to facilities providing insured hospital services, by type of facility:				
– acute care facilities	$17,094,366	$17,526,000	$17,651,846	$17,997,584
– cottage hospital	$1,473,481	$1,310,846	$1,371,771	$1,589,574
– chronic care facilities				
– rehabilitative care facilities				
– out-patient surgical facilities				
– out-patient diagnostic facilities				
– other facilities[2]	$6,589,755	$7,022,326	$7,718,202	$8,424,500
Total payments to all facilities providing insured hospital services	$25,157,602	$25,859,172	$26,741,819	$28,011,658
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services:				
– acute care facilities	$785.00	$785.00	$989.00	$989.00
– cottage hospital	$225.00	$225.00	$400.00	$400.00
– newborn rate	$165.00	$165.00	$165.00	$165.00
– chronic care facilities				
– rehabilitative care facilities				
8. Average per diem cost for out-patient care services by type of facility providing insured hospital services:				
– acute care facilities	$89.00	$89.00	$110.00	$110.00
– chronic care facilities				
– rehabilitative care facilities				
9. Average per diem cost for insured hospital services by type of facility:				
– acute care facilities	not available	not available	not available	not available
– cottage hospital	not available	not available	not available	not available
– chronic care facilities	not available	not available	not available	not available
– rehabilitative care facilities	not available	not available	not available	not available
10. Number of private health care facilities providing insured health services:				
– private surgical facilities	0	0	0	0
– private diagnostic facilities	0	0	0	0
11. Number of insured health services provided at:				
– private surgical facilities	0	0	0	0
– private diagnostic facilities	0	0	0	0
12. Total payments to:				
– private surgical facilities	$0	$0	$0	$0
– private diagnostic facilities	$0	$0	$0	$0

[2] Health Centres and Nursing Stations

Hospital Services Provided Out-of-territory (In-Canada)[3]				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-territory, in-patient, insured hospital services (in-Canada).	712	732	769	735
14. Total number of claims paid for out-of-territory, out-patient, insured hospital services (in-Canada).	5,621	6,109	6,637	7,025
15. Total payments for out-of-territory, in-patient, insured hospital services (in-Canada).	$4,751,127	$4,434,174	$4,196,661	$4,683,562
16. Total payments for out-of-territory, out-patient, insured hospital services (in-Canada).	$584,070	$645,165	$826,425	$920,769
17. Average payment for out-of-territory, in-patient insured hospital services (in-Canada).	$6,673	$6,058	$5,457	$6,372
18. Average payment for out-of-territory, out-patient hospital services (in-Canada).	$104	$106	$125	$131

Hospital Services Provided Out-of Country[4]				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.	11	14	13	11
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.	67	42	53	67
21. Total payments for out-of-country, in-patient, insured hospital services.	$62,847	$34,445	$45,440	$22,125
22. Total payments for out-of-country, out-patient, insured hospital services.	$32,462	$5,502	$7,354	$7,080
23. Average payment for out-of-country, in-patient insured hospital services.	$5,713	$2,460	$3,495	$2,011
24. Average payment for out-of-country, out-patient insured hospital services.	$485	$131	$139	$102

[3] Figures are by service date
[4] Figures are by service date

In-Territory Physician Services[5]				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians:				
– general practitioners	48	52	40	41
– specialists	4	4	4	5
– all physicians	52	56	44	46
26. Number of insured services provided, by category of physician (fee-for-service):				
– general practitioners	161,680	164,544	151,743	153,542
– specialists	12,522	10,885	14,170	11,704
– all physicians	174,201	175,429	165,913	165,246
27. Number of insured physician services provided, by category of service:				
– medical services	125,230	127,479	120,830	123,333
– surgical services	26,775	25,425	23,110	22,092
– diagnostic services	22,197	22,525	21,972	19,822
– all insured physicians services	174,201	175,429	165,912	165,246
28. Total payment to (fee-for-service) physicians for insured services by category of physicians:				
– general practitioners	$5,198,864	$5,335,775	$5,058,606	$5,248,704
– specialists	$1,076,028	$1,184,312	$1,321,577	$1,189,271
– all physicians	$6,274,892	$6,520,087	$6,380,183	$6,437,974
29. Total payment to physicians for insured services, by category of service:				
– medical services	$5,040,362	$5,182,278	$5,026,530	$5,144,453
– surgical services	$918,797	$995,148	$1,005,170	$978,628
– diagnostic services	$315,733	$342,660	$348,483	$314,893
– all insured physicians services	$6,274,892	$6,520,087	$6,380,183	$6,437,974
30. Average payment per service for insured (fee-for-service) physician services by category of physician:				
– general practitioners	$32.15	$32.43	$33.34	$34.18
– specialists	$85.93	$108.80	$93.27	$101.61
– all physicians	$36.02	$37.17	$38.45	$38.96
31. Average payment per service for insured physician services by category of service:				
– medical services	$40.25	$40.65	$41.60	$41.71
– surgical services	$34.32	$39.14	$43.50	$44.30
– diagnostic services	$14.22	$15.21	$15.86	$15.89
– all insured physician services	$36.02	$37.17	$38.45	$38.96

[5] Resident Yukon physicians and resident Yukon specialists providing services to Yukon Health Care Plan subscribers.

In-Territory Surgical-Dental Services[6]				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists.	12	10	12	9
33. Number of insured services provided by dentists.	309	203	296.5	214
34. Total payments to dentists for insured surgical-dental services.	$75,331	$50,840	$64,397	$59,458
35. Average payment per service for insured surgical-dental services.	$243.79	$250.44	$217.19	$277.84

Out-of-Territory Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-territory, insured physician services (in-Canada).	33,313	28,656	29,834	31,020
37. Total payments for out-of-territory, insured physician services.	$1,180,306	$1,183,519	$1,207,371	$1,404,195
38. Average payment per service for out-of-territory, insured physician services.	$35.43	$41.30	$40.47	$45.27

[6] Resident Yukon physicians and specialists only who made in excess of $7,000 in the fiscal year

In-Territory Physician Services[7]				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
39. Number of participating physicians:				
– general practitioners	not available	not available	not available	not available
– specialists	not available	not available	not available	not available
– all physicians	not available	not available	not available	not available
40. Number of insured services provided, by category of physicians (fee-for-service):				
– general practitioners	23,759	27,583	30,391	27,757
– specialists	11,411	11,848	10,443	11,332
– all physicians	35,170	39,431	40,834	39,089
41 Number of insured services provided, by category of service:				
– medical services	29,629	33,975	33,007	31,609
– surgical services	2,134	1,842	4,483	5,141
– diagnostic services	3,407	3,614	3,344	2,339
– all insured physician services	35,170	39,431	40,834	39,089
42 Total payment to (fee-for-service) physicians for insured services by category of physicians:				
– general practitioners	$815,233	$983,271	$994,636	$907,848
– specialists	$924,791	$756,719	$681,869	$727,972
– all physicians	$1,740,024	$1,739,990	$1,676,505	$1,635,820
43. Total payment to physicians for insured services, by category of service:				
– medical services	$1,415,810	$1,542,518	$1,477,892	$1,436,115
– surgical services	$232,831	$112,736	$121,755	$132,349
– diagnostic services	$91,383	$84,736	$76,857	$67,356
– all insured physician services	$1,740,024	$1,739,990	$1,676,504	$1,635,820
44. Average payment for insured (fee-for-service) physicians services by category of physicians:				
– general practitioners	$34.31	$35.65	$32.73	$32.71
– specialists	$81.04	$63.87	$65.29	$64.24
– all physicians	$49.47	$44.13	$41.06	$41.85
45. Average payment for insured physician services by category of service:				
– medical services	$47.78	$45.40	$44.78	$45.43
– surgical services	$109.11	$61.20	$27.16	$25.74
– diagnostic services	$26.82	$23.45	$22.98	$28.80
– all insured physician services	$49.47	$44.13	$41.06	$41.85

[7] Visiting Specialists, Locum Doctors & Member Reimbursements

Northwest Territories

With the division of the Northwest Territories into two separate Territories (Northwest Territories and Nunavut) on April 1, 1999, data is not available for 1996-1999 through to 1998-1999. These data would not be comparable to the data that has been provided for 1999-2000.

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000[1]**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes): - acute care facilities - chronic care facilities - rehabilitative care facilities - out-patient surgical facilities - out-patient diagnostic facilities - other facilities Total facilities				4 hospitals 28 health centres 32
2. Number of staffed beds in facilities providing insured hospital services, by category: - acute care beds - chronic care beds - rehabilitative care beds - day surgery beds Total staffed beds				 212[2]
3. Approved bed complements in facilities providing insured hospital services, by category: - acute care beds - chronic care beds - rehabilitative care beds - day surgery beds Total approved bed complement				 212
4. Number of separations from facilities providing insured hospital services, by type of care: - acute care beds - chronic care beds - rehabilitative care beds - day surgery beds *(not available from CIHI)* Total separations				 not available
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care: - acute care facilities - chronic care facilities - rehabilitative care facilities				 not available

[1] Projections have been made where data are incomplete.

[2] Frequently beds are re-formatted depending on need.

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000[1]**
6. Total payments to facilities providing insured hospital services, by type of facility: - acute care facilities - chronic care facilities - rehabilitative care facilities - out-patient surgical facilities - out-patient diagnostic facilities - other facilities Total payments to all facilities providing insured hospital services				not available not available
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative care facilities				not available
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative care facilities				not available
9. Average per diem for insured hospital services by type of facility: - acute care facilities - chronic care facilities - rehabilitative care facilities				not available not available not available
10. Number of private facilities providing insured health services - private surgical facilities - private diagnostic facilities Total				0 0 0
11. Number of insured health services provided at: - private surgical facilities - private diagnostic facilities Total				0 0 0
12. Total payments to: - private surgical facilities - private diagnostic facilities Total				0 0 0

Hospital Services Provided Out-of-Territory (In-Canada) (Claim Type TI)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-territory, in-patient, insured hospital services (In-Canada).				992
14. Total number of claims paid for out-of-territory, out-patient, insured hospital services (in-Canada).				7,556
15. Total payments for out-of-territory, in-patient, insured hospital services (in-Canada).				$6,714,719.40
16. Total payments for out-of-territory, out-patient, insured hospital services (in-Canada).				$1,077,810.04
17. Average payment for out-of-territory, in-patient insured hospital services (in-Canada).				$6,768.87
18. Average payment for out-of-territory, out-patient hospital services (in-Canada).				$142.64

Hospital Services Provided Out-of-Country (Claim Type TI)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.				40
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.				64
21. Total payments for out-of-country, in-patient, insured hospital services.				$135,652.77
22. Total payments for out-of-country, out-patient, insured hospital services.				$27,202.85
23. Average payment for out-of-country, in-patient insured hospital services.				$3,391.32
24. Average payment for out-of-country, out-patient hospital services.				$425.04

In-Territory Physician Services (Claim Type MO & MS)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians: - general practitioners - specialists - all physicians				 not available not available not available
26. Number of insured services provided, by category of physicians (fee-for-service): - general practitioners - specialists - other physicians - all physicians				 165,442 55,600 7,504 227,546
27. Number of insured physician services provided: - medical services - surgical services - diagnostic services - all insured physician services				 not available not available not available 228,792
28. Total payments to (fee-for-service) physicians for insured services, by category of physicians: - general practitioners - specialists - other physicians - all physicians				 $5,858,751.12 $703,525.74 $361,024.29 $6,923,301.15
29. Total payments to physicians for insured services. - medical services - surgical services - diagnostic services - all insured physician services				 not available not available not available $6,923,301.15
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians: - general practitioners - specialists - others - all physicians				 $73.14 $34.38 $24.01 $48.03
31. Average payment per service for insured physician services: - medical services - surgical services - diagnostic services - all insured physician services				 not available not available not available $30.26

In-Territory Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists. (i.e. dentists who received payments in the year)				not available
33. Number of insured services provided by dentists.				not available
34. Total payments to dentists for insured surgical-dental services.				not available
35. Average payment per service for insured surgical-dental services.				not available

Out-of-Territory Physician Services (In Canada) (Claim Type MO)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-territory, out-patient, insured physician services (in-Canada).				15,694
37. Total payments for out-of-territory, out-patient, insured physicians services.				$701,824.26
38. Average payment for out-of-territory, out-patient physician services.				$44.72

Nunavut

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
1. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes): - acute care facilities - chronic care facilities - rehabilitative facilities - out-patient surgical facilities - out-patient diagnostic facilities - other facilities Total facilities				1 hospital 25 health centres 26
2. Number of staffed beds in facilities providing insured hospital services, by category: - acute care beds - chronic care beds - rehabilitative beds - day surgery beds Total staffed beds				not available not available not available not available not available
3. Approved bed complements in facilities providing insured hospital services, by category: - acute care beds - chronic care beds - rehabilitative care beds - day surgery beds Total approved bed complement				not available not available not available not available not available
4. Number of separations from facilities providing insured hospital services, by type of care: - acute care beds - chronic care beds - rehabilitative care beds - day surgery beds (not available from CIHI) Total separations				not available not available not available not available not available
5. Average length of in-patient stay (# of days) in facilities providing insured hospital services, by type of care: - acute care facilities - chronic care facilities - rehabilitative care facilities				not available not available not available
6. Total payments to facilities providing insured hospital services, by type of facility: - acute care facilities - chronic care facilities - rehabilitative care facilities - out-patient surgical facilities - out-patient diagnostic facilities - other facilities Total payment to all facilities providing insured hospital services				not available not available not available not available not available not available not available

In-Territory Hospital Services				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
7. Average per diem cost for in-patient care services by type of facility providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative care facilities.				not available not available not available
8. Average per diem cost for out-patient care services by type of facilities providing insured hospital services: - acute care facilities - chronic care facilities - rehabilitative care facilities.				not available not available not available
9. Average per diem cost for insured hospital services by type of facility: - acute care facilities - chronic care facilities - rehabilitative care facilities.				not available not available not available
10. Number of private health care facilities providing insured health services: - private surgical facilities - private diagnostic facilities Total				not available not available not available
11. Number of insured health services provided at: - private surgical facilities - private diagnostic facilities Total				not available not available not available
12. Total payments to: - private surgical facilities - private diagnostic facilities Total				not available not available not available

Hospital Services Provided Out-of-Territory(In-Canada)				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
13. Total number of claims paid for out-of-territory, in-patient, insured hospital services (in-Canada).				1,842
14. Total number of claims paid for out-of-territory, out-patient, insured hospital services (in-Canada).				9,656
15. Total payments for out-of-territory, in-patient, insured hospital occurrences (in-Canada).				$8,546,013
16. Total payments for out-of-territory, out-patient, insured hospital occurrences (in-Canada).				$1,470,018
17. Average payment for out-of-territory, in-patient insured hospital occurrences (in-Canada).				$4,639
18. Average payment for out-of-territory, out-patient hospital occurrences (in-Canada).				$152

Hospital Services Provided Out-of-Country				
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
19. Total number of claims paid for out-of-country, in-patient, insured hospital services.				14
20. Total number of claims paid for out-of-country, out-patient, insured hospital services.				5
21. Total payments for out-of-country, in-patient, insured hospital services.				$12,010
22. Total payments for out-of-country, out-patient, insured hospital services.				$1,130
23. Average payment for out-of-country, in-patient insured hospital services.				$857
24. Average payment for out-of-country, out-patient hospital services.				$226

In-Territory Physician Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
25. Number of participating physicians: - general practitioners - specialists - all physicians				 85 79 164
26. Number of insured services provided, by category of physicians (fee-for-service): - general practitioners - specialists - all physicians				 50,914 23,120 74,034
27. Number of insured physician services provided, by category of services: - medical services - surgical services - diagnostic services - all insured physician services.				 not available not available not available not available
28. Total payments to (fee-for-service) physicians for insured services, by category of physicians: - general practitioners - specialists - all physicians				 $2,323,234 $1,146,522 $3,469,756
29. Total payments to physicians for insured services, by category of services: - medical services - surgical services - diagnostic services - all insured physician services				 not available not available not available not available
30. Average payment per service for insured (fee-for-service) physician services, by category of physicians: - general practitioners - specialists - all physicians				 $45.63 $49.59 $46.86
31. Average payment per service for insured physician services, by category of services (based on specialty of the physician): - medical services(medical specialists) - surgical services(surgical specialists) - diagnostic services+ (laboratory & x-ray specialists) - all insured physician services.				 not available not available not available not available

In-Territory Surgical-Dental Services				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
32. Number of participating dentists (i.e. dentists who received payments in the year)				27
33. Number of insured services provided by dentists				0
34. Total payments to dentists for insured surgical-dental services				0
35. Average payment for insured per service surgical-dental services				0

Out-of-Territory Physician Services (In Canada)				
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**
36. Number of services paid for out-of-territory, insured physician services (in-Canada).				not available
37. Total payments for out-of-territory, insured physicians services.				not available
38. Average payment per service for out-of-territory, insured Physician services.				not available

CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6

L.R. (1985), ch. C-6

June, 1999

Juin 1999

Canada Health Act (R.S. 1985, c. C-6)
Source: http://canada.justice.gc.ca/en/laws/C-6/text.html
(Updated to April 30, 2000)
Subject: Health

Canada Health Act

CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

WHEREAS the Parliament of Canada recognizes:

--that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

--that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

--that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

--that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

--that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *«dentiste»*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *«services complémentaires de santé»*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" *«surfacturation»*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime d'assurance-santé»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel de la santé»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *«services hospitaliers»*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" «*services de santé assurés*» "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" «*assuré*» "insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" «*médecin*» "medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" «*ministre*» "Minister" means the Minister of Health;

"physician services" «*services médicaux*» "physician services" means any medically required services rendered by medical practitioners;

"resident" «*habitant*» "resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" «*services de chirurgie dentaire*»

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" «*frais modérateurs*»

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

6. [Repealed, 1995, c. 17, s. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

1984, c. 6, s. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(*c*) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (*a*), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(*b*) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation

can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations

for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(*a*) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13(*b*).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(*a*) or (*b*) except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(*a*) if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(*c*) or (*d*) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

REPORT TO PARLIAMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

Glossary

The Glossary of the *Canada Health Act Annual Report* 1999-2000 presents explanations and terms used in the Report. Where terminology differs from those terms identified, this has been indicated.

Term	Explanation
Acute Care Facility	An acute care facility is a hospital providing care or treatment of patients with an acute disease or health condition.
Acute Care Bed	An acute care bed is a bed in a hospital which has been designated for the treatment or care of an inpatient with an acute disease or health condition.
Admission	The official acceptance into a health service facility and the assignment of a bed to an individual requiring medical and/or health services on a time-limited basis.
Approved Beds	Number of beds that a facility has been approved to operate in order to provide health services. (Approval is by the province, territory or the federal government in the case of a federal hospital.)
Average Per Diem Cost	The estimated average amount that a province or territory establishes as the average daily cost of a treatment or stay. The estimate can be derived by dividing total annual costs of treatments or stays (or total program cost) by the average length of stay (or treatment) in the year and total number of patients (or separations) in the year.
Block Fees	A fee for a defined period of time that a physician may charge their patients for services not covered under the provincial/territorial health insurance plan. The uninsured services may include items such as telephone advice at the patient's request, renewal of prescriptions by telephone, and completion of various forms and documents.
Chronic Care Bed	Bed designated for ongoing in-patient, long-term medical services.
Chronic Care Facility	Facility providing ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.
Coordinating Committee on Reciprocal Billing (CCRB)	The Coordinating Committee on Reciprocal Billing (CCRB) of federal, provincial and territorial officials, was formed in 1991 to identify and discuss issues arising from interprovincial billing arrangements for medical and hospital services. Committee members are also mandated to resolve administrative complexities at the operational level.
Day Surgery Bed	Bed designated for short-term (less than 24 hours) surgical services in a hospital setting.

Term	Explanation
Diagnostic Service	A procedure that diagnoses various diseases and/or conditions.
Eligibility and Portability Agreement (EPA)	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by Provincial/Territorial Ministers of Health in 1971 and implemented in 1972. The Agreement sets minimum standards with respect to interprovincial/territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	Medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.
Extra-billing	The billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Fee-for-service	A method of payment for physicians based on a fee schedule that itemizes each service.
General Practitioner	A licensed physician in a province or territory who practices community based medicine and refers patients to specialists when the diagnosis suggests it is appropriate.
Hospital	A hospital is a health care facility located in Canada that provides medical, surgical or psychiatric care and treatment for the sick or injured, including acute, rehabilitative or chronic care, but does not include an institution primarily for the mentally disordered, nor does it include a facility or portion thereof that provides nursing home care, adult residential care, or comparable services for children.
Hospital Reciprocal Billing Agreement	A bilateral agreement between provinces/territories that allows for the reciprocal processing of out-of-province/territory claims for hospital in-patient and out-patient services. Under such an agreement, insured hospital services are payable at the approved rates of the host province/territory or as otherwise agreed upon by the parties involved and/or the Coordinating Committee on Reciprocal Billing (CCRB).
In-patient	A patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Service	Insured hospital, physician and surgical-dental services.

Term	Explanation
Insured Hospital Services	Hospital services include any of the following services provided to in- or out-patients at a hospital if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability: ❑ accommodation and meals at the standard or public ward level and preferred accommodation if medically required; ❑ nursing service; ❑ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; ❑ drugs, biologicals and related preparations when administered in the hospital; ❑ use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; ❑ medical and surgical equipment and supplies; ❑ use of radiotherapy facilities; ❑ use of physiotherapy facilities; and ❑ services provided by persons who receive remuneration therefore from the hospital, but not those services excluded by the *CHA* regulations.
Insured Physician Service	A medically required service covered by a provincial/territorial health insurance plan and administered by a medical practitioner.
Insured Surgical-Dental Service	A medically or dentally required surgical-dental procedure performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure.
Length of Stay	Number of days a patient is admitted to a health services facility.
Medical Services	A non-surgical service provided by a licensed provincial or territorial physician or medical practitioner.
Medical Reciprocal Billing Agreement	A bilateral agreement between provinces/territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licenced physician. Where an agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Opted out Physicians	Physicians who operate outside the provincial/territorial health insurance plan, meaning that they bill their patients directly at the provincial/territorial rate. The provincial/territorial plan does reimburse these patients for charges up to, but not more than the amount paid by the plan for that service under its fee schedule agreement.

Term	Explanation
Out-patient	A patient who is admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Facility	Facility providing short-term (day only) insured diagnostic services.
Out-patient Surgical Facility	Facility providing short-term (day only) insured surgical services.
Participating Physician/Dentist	A licensed physician/dentist who is enrolled in a provincial/territorial health insurance plan.
Private Diagnostic Facility	A privately owned facility providing laboratory, radiological and other diagnostic procedures to patients as defined in the *Canada Health Act*.
Private Surgical Facility	A privately owned facility providing surgical health services to patients as defined in the *Canada Health Act*.
Non-Participating Physician	A physician operating completely outside the provincial/territorial health insurance plan. Neither the physician nor the patient is eligible for any cost coverage for services either rendered or received from the provincial or territorial health insurance plan. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Private *(not-for-profit)* Facility	A privately owned facility providing insured health services on a not-for-profit basis.
Private *(for-profit)* Facility	A privately owned facility providing insured health care services on a for-profit basis (e.g., charges cover costs and a rate of return on investment).
Private Health Care Facility	Includes such private facilities as the Shoudice Hospital, Morgentaler Clinics, and Gimbel Eye Centres.
Public Health Facility	A public health facility is a publicly administered health care institution located within Canada and providing publicly insured health care services on an in-patient or out-patient basis.
Rehabilitative Bed	Bed designated for in-patient, rehabilitative treatment services in a hospital setting (e.g., rehabilitative treatment for spinal or head injuries).
Rehabilitative Facility	Facility providing rehabilitative, in-patient insured services.
Resident	A person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.
Separations	The total number of in-patients and out-patients who are released from a health facility following their discharge, transfer, day surgery or death.

Term	Explanation
Specialist	A licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures.
Staffed Beds	Number of beds for which a health care facility has staff to provide health services.
Surgical Services	A service provided by a physician that is deemed to be surgical by a province or territory for billing purposes.
Temporarily Absent	To be absent from the province or territory of origin for business, education, vacation or other reasons without assuming permanent residence elsewhere and presumably intending to return.
Third-Party Payers	Organizations such as Workers' Compensation Boards, private health insurance companies, employer-based health care plans, etc., which pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges for items such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.
User Charge	Any charge for an insured health service that is authorized or permitted by a provincial/territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health insurance plan, but does not include any charge imposed by extra-billing.